PERSONAL INFORMATION

NAME ____
(last) (first) (middle)

ADDRESS ____
(street/box) (city/town) (postal code)

HOME # ______________ WORK # ______________ CELL # ______________

BIRTHDATE ______________ AGE ________ GENDER ______________
(d/m/y) (male/female)

EMPLOYER ______________ OCCUPATION ______________

WORK ADDRESS ____
(street/city/postal code)

NAME OF PARENT OR GUARDIAN ____
(if under 18yrs)

PERSON RESPONSIBLE FOR ACCOUNT ______________________________ SELF ☐

MARITAL STATUS ______________ E-MAIL ______________

PATIENTS A.H.C.# ______________

PATIENTS S.I.N.# ______________

HOW DID YOU HEAR ABOUT US? ______________

DENTAL INSURANCE

PRIMARY INSURANCE

NAME OF SUBSCRIBER ______________ D.O.B. (d/m/y) ______________

INSURANCE COMPANY ______________

POLICY/GROUP NO. ______________ CERT/ID # ______________

EMPLOYER ______________

SECONDARY INSURANCE

NAME OF SUBSCRIBER ______________ D.O.B. (d/m/y) ______________

INSURANCE COMPANY ______________

POLICY/GROUP NO. ______________ CERT/ID # ______________

EMPLOYER ______________

DENTAL HISTORY

Name of last Dentist ______________ Phone ______________

City ______________ Postal Code ______________

Date of last complete dental exam Day ________ Month ________ Year ________

Past experience of dental treatment ____

____

Present dental concerns ____

Are you interested in whitening? **YES/NO** Are you interested in straightening? **YES/NO**

TREATMENT CONSENT

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF THE DENTAL AND ORAL SURGERY PROCEDURES AGREED OR ADVISABLE, INCLUDING THE USE OF LOCAL ANAESTHETIC AS INDICATED. I FULLY UNDERSTAND THE OFFICIAL POLICY AND I WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THOSE PROCEDURES PERFORMED.

I AUTHORIZE RELEASE TO MY INSURANCE COMPANY PLAN ADMINISTRATOR, THE INFORMATION CONTAINED IN CLAIMS SUBMITTED ELECTRONICALLY: I HEREBY ASSIGN MY BENEFITS, PAYABLE FROM CLAIMS SUBMITTED ELECTRONICALLY, TO DR. JINNAH AND AUTHORIZE PAYMENT DIRECTLY TO HER. PLEASE ACCEPT THIS SIGNATURE TO PROCESS ELECTRONIC CLAIMS:

PATIENT'S (PARENT'S) SIGNATURE ______________ DATE ______________