DOON VILLAGE DENTAL

REGISTRATION FORM

(Please Print)

Today's date: MM/DD/YYYY			PID no.:	
PATIENT INFORMATION				
❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr. ❑ Other Patient's last name: Given name(s)			Birth date: MM/DD/YYYY	Age:	Sex: ❑ M ❑ F ❑ Other
Address:		Home phone no.: ( )		Cell phone no.: ( )	
City:	Province:	Postal Code:	e-mail:		
Occupation:	Employer:		Employer phone no.: ( )		
How have you heard about us? (please check one box): ❑ Referred by Dr. ❑ Internet Search (Google, etc.) ❑ Website/Social Media ❑ Family ❑ Friend ❑ Close to home/work ❑ Other:					
Other family members seen here:					
Physician's name:			Phone no.: ( )		
Pharmacy			Phone no.: ( )		

All information collected is considered confidential and managed in compliance with the personal health information protection act.
Do we have the permission to contact you by phone or email? **❑ YES, ❑ YES Only:_____, ❑ NO**

Your appointment time given is reserved for you personally. Consider your appointment confirmed. Respectfully, if you are unable to keep the appointment, we require two full business days' notice. Failure to extend this courtesy may result in a fee.

Patient's initials: _____

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
PRIMARY DENTAL INSURANCE			SECONDARY DENTAL INSURANCE		
Name of Insured:	DOB: MM/DD/YYYY		Name of Insured:	DOB: MM/DD/YYYY	
Address (if different):			Address (if different):		
Employer:			Employer:		
Insurance carrier:			Insurance carrier:		
Group policy no.:	Primary certificate or ID #:	Division:	Group policy no.:	Primary certificate or ID #:	Division:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:					

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Doon Village Dental or insurance company to release any information required to process my claims.			
Patient/Guardian signature		Date: MM/DD/YYYY	