



28498 Centre Road, Strathroy, ON, N7G 3H6

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## Patient Registration Form

Patient Name: \_\_\_\_\_

Prefers to be called (if different from above): \_\_\_\_\_

Parent/Guardian Name (If patient under 18 years of age): \_\_\_\_\_

Address (Street): \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Date of Birth (DD/MM/YYYY): \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

How would you like us to remind you of your appointments?  Phone  Text  Email  All Three

*\*We reserve this time for you and request 2 full business days' notice to avoid a cancellation fee.  
Changes to appointments can only be made by phone.*

Partner/Spouses Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Whom may we thank for referring you: \_\_\_\_\_

Are any of your family members patients: \_\_\_\_\_

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## Dental Insurance (if applicable)

Do you have dental insurance?  YES  NO

Primary Dental Insurance Company: \_\_\_\_\_

Group/Policy Number: \_\_\_\_\_ ID/Certificate Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Secondary Dental Insurance Company: \_\_\_\_\_

Group/Policy Number: \_\_\_\_\_ ID/Certificate Number: \_\_\_\_\_

Employer: \_\_\_\_\_

I authorize release to my dental plan administrator and the CDA information contained in claims submitted electronically. I also authorize the communication of information related to coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

Signature \_\_\_\_\_

Date \_\_\_\_\_