Caradoc Dentistry

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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: _____

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: _____

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