PATIENT INFORMATION

Patient Name:_____ **Date:**_____
Last First Middle

Address:_____

_____ Sex: ☐ Male ☐ Female
City Province Postal Code

Date of Birth :_____ /_____ /_____ Alberta Health Care No._____
Month Day Year

Home :(_____) _____-_____ Work :(_____) _____-_____ Ext: _____ Cell :(_____) _____-_____

E-mail Address:_____

Best time and place to contact you:_____

Spouse's Name:_____

IN CASE OF EMERGENCY, CONTACT (Someone who does not live in your household.)

Name:_____ Relationship:_____

Home Phone: (_____)_____-_____ Work Phone:(_____)_____-_____ Ext:_____

Who may we thank for referring you to our office? _____

DENTAL BENEFITS

First Insurance Coverage: Insurance Company Name:_____

Subscriber Name:_____ Relationship to Patient:_____

Subscriber's Date of Birth:_____/_____/_____ Employer:_____
Month Day Year

Group Number:_____ ID #:_____

Second Insurance Coverage: Insurance Company Name:_____

Subscriber's Name:_____ Relationship to Patient:_____

Subscriber's Date of Birth:_____/_____/_____ Employer:_____
Month Day Year

Group Number:_____ ID #:_____

CONSENT AND RELEASE:

I understand that I am financially responsible for all charges. In consideration of the services rendered to me by Signature Dentistry, I am obligated to pay the full amount in accordance with its credit terms and policy. I consent to the taking of photographs and x-rays before, during and after treatment, and to the doctor's use in demonstrations. I also authorize the Dentist to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

To the best of my knowledge, all the Dental / Health History answers are correct. If I have any changes in my health status or if my medicine changes, I shall inform the dentist and staff at my next appointment.

I certify that I have read or had read to me the contents of this form. I understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome or results of treatment can be made.

Patient Signature (Parent/Guardian of Child):_____ **Date**:_____

Staff Signature:_____ **Date:**_____

DENTAL REGISTRATION