

# NORTH VAN DENTAL

## NEW PATIENT INFORMATION FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Prov.: \_\_\_\_\_ Postal code: \_\_\_\_\_ Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_ \*Opt in Newsletter: Yes No

Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_ If child, parent's name: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

If student, name of school: \_\_\_\_\_ Grade: \_\_\_\_\_

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

Credit Card Info: Visa MC AMEX Card #: \_\_\_\_\_ Exp. date: \_\_\_\_\_ CSV #: \_\_\_\_\_

DL#: \_\_\_\_\_ SI#: \_\_\_\_\_

### Responsible Party *(Please complete all information if different from above)*

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Home phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Is this person currently a patient in our office? YES NO

### Insurance Information

Name of insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance company: \_\_\_\_\_

Insurance year end: \_\_\_\_\_ Group/individual policy #: \_\_\_\_\_ ID / Certificate #: \_\_\_\_\_

Annual maximum: \$ \_\_\_\_\_ Annual deductible: \$ \_\_\_\_\_

Percentage coverage: Basic: \_\_\_\_\_% Major: \_\_\_\_\_% Ortho: \_\_\_\_\_%

Recall frequency: \_\_\_\_\_ Polish/fluoride frequency: \_\_\_\_\_ Scaling/root planing limit: \$ \_\_\_\_\_ #units: \_\_\_\_\_

### Do you have additional insurance? YES NO If yes, complete the following:

Name of insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance company: \_\_\_\_\_

Insurance year end: \_\_\_\_\_ Group/individual policy #: \_\_\_\_\_ ID / Certificate #: \_\_\_\_\_

Annual maximum: \$ \_\_\_\_\_ Annual deductible: \$ \_\_\_\_\_

Percentage coverage: Basic: \_\_\_\_\_% Major: \_\_\_\_\_% Ortho: \_\_\_\_\_%

Recall frequency: \_\_\_\_\_ Polish/fluoride frequency: \_\_\_\_\_ Scaling/root planing limit: \$ \_\_\_\_\_ #units: \_\_\_\_\_

Signature of patient or parent if minor: \_\_\_\_\_

\*By opting in to our patient newsletter you will receive monthly updates from our office. You may also receive periodical email updates informing you of our specials and promotions. You will be able to unsubscribe at any time.