HARBOUR CENTRE DENTAL

NEW PATIENT INFORMATION FORM

Clear Form | Print

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.