PROVIDENCE FAMILY DENTAL CARE

273 Finch Ave. W, North York, ON M2R 1M8
Tel.: (416) 633-2433 Fax: (416) 633-8428

PATIENT REGISTRATION FORM
File No.:
Medical Alert:

Your cooperation in completing this form is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form

PATIENT IDENTIFICATION Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Miss
☐ Mr
☐ Mrs.
☐ Ms.

Last Name | First Name(s) | Middle Name(s)

Nickname | Date of Birth (Month/Day/Year) | Parent/Guardian Name (if under 18)

CONTACT ADDRESS

Street No. And Name | Unit No. | City | Province | Postal Code

CONTACT NUMBER Preferred Contact Methods: ☐ Home ☐ Mobile ☐ Work ☐E-mail

Home | Mobile | Work (Include extension) | E-mail Address

WORK INFORMATION

Your Occupation | Your Employer | Spouse's Occupation | Spouse's Employer

FAMILY PHYSICIAN INFORMATION

Name | Street No, Name and Unit No. | City | Province | Contact No.

EMERGENCY CONTACT INFORMATION

Name | Relationship to Patient | Contact No.

WHO MAY WE THANK FOR YOUR REFERRAL?

☐ Patient: ____________________ ☐ Others: ____________________

REASON FOR TODAY'S VISIT ☐ Consultation ☐ Emergency ☐ Cleaning and Checkup ☐ Others: ____________

Who will be responsible for patient's account?

☐ Self ☐Government Program: ____________
☐ Insurance ☐Other (s) : ____________

If insurance or Government Assistance will be responsible for patient's account, kindly provide the account information below:

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber's Name / Insurance Carrier	Subscriber's Name / Insurance Carrier
Policy Number / Certificate number	Policy Number / Certificate number
Date of Birth (m/d/y)	Date of Birth (m/d/y)
BREAKDOWN: (To be filled up by the receptionist)	**BREAKDOWN: (To be filled up by the receptionist)**
Recall: / Percent Coverage (%):	Recall: / Percent Coverage (%):
Scaling: / Fee Guide:	Scaling: / Fee Guide:
Max Limit:	Max Limit:
Cal. Yr.:	Cal. Yr.:
Major:	Major: