AUBURN BAY DENTAL

PERSONAL INFORMATION: (please circle) Dr. Mr. Mrs. Ms. Miss.

Name: Last_____ First_____ Middle_____
Preferred Name: _____ Birthdate (DD/MM/YY):____/____/_____
Home Address: _____City: _____
Province: _____ Postal Code: _____ E-Mail: _____
Phone Numbers: Home _____ Work _____ Cellular_____
Employer: _____

IF PATIENT IS A MINOR: Parent/Guardian Information:
Name: Last _____ First _____ Middle_____
Address (if different from above): _____
City: _____ Province: _____Postal Code: _____ E-Mail: _____
Phone Numbers: Home _____ Work _____Cellular _____

WHOM CAN WE THANK FOR REFERRING YOU TO OUR CLINIC?

_____

ELECTRONIC INSURANCE SUBMISSIONS

We extend the courtesy of sending your insurance claim electronically. Due to the Canadian Personal Privacy Act, the details of your dental insurance plan are kept confidential. We are unable to access this information. Please be informed of the details of your dental plan that were provided to you by your insurer. It is your responsibility to know these details, including annual maximums, frequencies, and any other limitations. We are happy to assist you if you have any questions.

CANCELLATION POLICY

We look forward to seeing you at your reserved appointment. Should you need to reschedule your appointment, please contact us a minimum of 2 business days prior to your reserved appointment time. If insufficient notice is given, a $50.00 fee may be charged. Thank you.

I have read and I understand the above policies. All information will be kept confidential.

Patient/Guardian Signature:_____Date_____