PATIENT INFORMATION

NAME:_____ BIRTHDATE: _____ GENDER:_____

ADDRESS:_____ CITY: _____

POSTAL CODE: _____ EMAIL ADDRESS:_____

HOME:_____ WORK:_____ CELL: _____

HOW WOULD YOU LIKE TO BE CONTACTED? EMAIL:__ PHONE:__ BEST CONTACT:_____

REFERRED BY: _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:_____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL PLAN

POLICY HOLDER : _____

BIRTHDATE:_____

EMPLOYER: _____

INSURANCE COMPANY: _____

GROUP # _____

I.D./CERT # _____

BASIC (A):_____% LIMIT $_____

MAJOR (B):_____% LIMIT $ _____

RECALLS (MOS): 6 9 12

SCALING/RP: _____ UNITS PER YEAR

SECONDARY DENTAL PLAN

POLICY HOLDER :_____

BIRTHDATE:_____

EMPLOYER: _____

INSURANCE COMPANY: _____

GROUP # _____

I.D./CERT # _____

BASIC (A):_____% LIMIT: $ _____

MAJOR (B): _____% LIMIT: $_____

RECALLS (MOS): 6 9 12

SCALING/RP: _____ UNITS PER YEAR

AUTHORIZATION FOR RELEASE OF INFORMATION

In regards to the Personal Information Protection and Electronic Documents Act:

I, _____authorize release to Tyler Dental Artz information contained in pre-authorizations and claims submitted electronically and otherwise. I also authorize release of information pertaining to my dental coverage and benefits.

_____ _____

Signature of Patient, Parent or Guardian Date