PATIENT INFORMATION (CONFIDENTIAL)

Name:_____ **[ ] Male [ ] Female**
(last) (first) (initial)

Mailing Address: _____

City:_____ **Postal Code:** _____

Date of Birth:_____ **Age:** _____ **Marital Status:**_____

Email:_____
☐ *I do <u>not</u> consent to receiving e-mails from Medora Dental Care*

Home phone:_____ **Work phone:**_____ **Cell phone:**_____

Please check your preferred contact:
☐ Home phone ☐ Work phone ☐ Cell phone ☐ E-mail

SIN:_____ **PHN (Care card #):** _____

Employer/Occupation:_____

Emergency phone #: _____ **Name and relationship to patient:**_____

How did you hear about us? ☐ Facebook ☐ Internet search ☐ Rate MDS ☐ Drive/walk-by
☐ Yellowpages ☐ Other: _____ ☐ Friend/family referral: _____

Please check one of the following options:
☐ I give consent for Medora Dental Care to submit my insurance claims/pre-authorizations to my dental insurance provider including any supporting documentation needed for approval/payment.
☐ I do not have insurance and will pay in full for all dental services.

- Payment is due after each appointment. We accept Cash, Interac, Visa & Mastercard
- Our office requires a full 2 business days notice, within office hours, for appointment changes
- If less notice is given, a broken appointment fee will be charged

Signature of Patient, Parent/Guardian:_____ Date:_____