Patient

Name _____
Last First MI (Preferred)

Date of Birth _____ Health Card # _____ Gender [X] M [ ] F

Phone _____ Mobile Phone _____

Email _____

Preferred contact method: [ ] Phone [ ] Wireless Phone [ ] Email

Name of Responsible Parent or Guardian 1 _____ Relationship to Child _____

Name of Responsible Parent or Guardian 2 _____ Relationship to Child _____

How did you hear about us? _____

(If someone referred you here, please write down their name so we can thank them.)

Address

Check box if same for entire family [X]

Address _____

Address 2 _____

City _____ Province _____ Postal Code _____

Insurance Policy #1

Please present insurance card(s) to receptionist.

Patient's relationship to subscriber: [X] Self [ ] Spouse [ ] Child Date of Birth _____

Subscriber Name _____ Subscriber ID # _____

Insurance Company _____ Phone _____

Employer _____ Policy Name (optional) _____ Policy # _____

Insurance Policy #2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child Subsriber's DOB: _____

Subscriber Name _____ Subscriber ID # _____

Insurance Company _____ Phone _____

Employer _____ Policy Name (optional) _____ Policy # _____

Additional Comments: _____

_____

I authorize release, to my benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to Coral Kids Dentistry. This authorization shall continue in effect until the undersigned revokes the same.

Patient/Parent/Guardian Signature: _____ Date: 2021-03-03