Dental On Main

WELCOME TO OUR OFFICE!

The information that is requested on this Questionnaire and Dental/Medical Health Form is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using, and disclosing this information responsibly. **All information is confidential.** PLEASE PRINT.

Date: _____

Patient Information

Dr. ☐ Mrs. ☐ Mr. ☐ Ms. ☐

Last Name: _____ First Name: _____ Initial: _____

Prefer to be called: _____ Date of Birth: _____ Age: _____

Sex: M ☐ F ☐ Marital Status: _____ Health Card #: _____

Home Address: _____

City: _____ Province/State: _____ Postal/Zip Code: _____

Home Tel.#: (_____)_____ Cell #: (_____)_____

Business Tel.#: (_____)_____ Occupation: _____ E-mail: _____

Family Physician:
First Name: _____ Last Name: _____ Tel.#: (_____)_____

Emergency Contact:
Name: _____ Relation: _____ Tel.#: (_____)_____

Whom may we thank for referring you? _____

Insurance Information

Do you have dental insurance? YES ❑ NO ❑

Primary Dental Insurance:

Name of Policy Holder: _____ Birthdate: _____

Company Name: _____

Group/Policy No: _____ Certificate/ID No: _____

Secondary Dental Insurance:

Name of Policy Holder: _____ Birthdate: _____

Company Name: _____

Group/Policy No: _____ Certificate/ID No: _____