Please visit our website: www.CreatingExceptionalSmiles.com

Personal/Insurance Information:

Name:_________________________ Sex M__F__ Birthdate(M/D/Yr)___________
Healthcard# ________________________
Address:_______________________/_____/ _____________/______/____________
Street Apt# City Prov. Postal Code
Business Phone#:______________________Home Phone#:__________________
Cell Phone#__________________ Emergency Contact#:__________________
E-mail address:______________________________________(for appointment reminders)
Person responsible for account:____

How did you hear of our office? (please check any that apply)
Advertising ___ (please specify) ____
Web site _______ Signage _____
Referal by patient _____If so by whom_________________________________
Telephone directory ____ If so which one _______________________________

I will most often pay my account by:
____Cash ____Debit ____Cheque ___Visa/Mastercard

Insurance Information: (Please bring your coverage information)
Policy Holder 1: ___________________Date of Birth:_________________________
Name of Insurance Company:____
Employed By:____
Group/ Policy :___________________Certificate:____________________________

Policy Holder 2: ___________________Date of Birth:_________________________
Name of Insurance Company:____
Employed By:____
Group/ Policy :___________________Certificate:____________________________

- Please understand that we require 2 business days notice for changes to appointments to avoid a rescheduling fee. Changes in appointment times with due notice must be made during business hours (8:00-5:00).
- Payment for services is required at the time of service (unless other payment options are agreed to in advance).
- I understand that I am responsible for reporting any changes or cancellation of my insurance plan.
- I understand that all fees may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment.

Signature:_______________________________________ Date:_________________

1) What attracted you to our office?____
____
2) Are you comfortable with dental treatment? Or have you had any bad experiences?
____
____
3) On a scale of 1-10 are you happy with your smile? (10 being the highest) ________
4) Do you have specific goals/requests for dental treatment?___________________________
____

Please complete other side