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### **Patient Information**

Name: \_\_\_\_\_  
Last First MI (Preferred Name)

Address: \_\_\_\_\_  
Street Apt #

City Province Postal Code

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Ext \_\_\_\_\_ (Cell) \_\_\_\_\_

E-mail: \_\_\_\_\_ May we e-mail our newsletters & special offers?  Yes  No

Date of Birth (Year/Month/Day): \_\_\_\_\_ S.I.N: \_\_\_\_\_

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### **Employment Information**

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City Province Postal Code Phone

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### **Referral Information**

How did you hear of our dental practice?

Patient, friend  Patient, relative  Our Website ([www.georgiadental.ca](http://www.georgiadental.ca))  Google/Google Maps  Yahoo

Internet site: \_\_\_\_\_  Specialist/Other Dr.: \_\_\_\_\_

Ad  CanPages  Yellow Pages  Hotel: \_\_\_\_\_  Other: \_\_\_\_\_

Whom may we thank for referring you to our practice? (Name): \_\_\_\_\_

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### **Insurance Information**

#### **Primary Dental Insurance**

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Group/Policy # \_\_\_\_\_ Division \_\_\_\_\_

ID/Certificate #: \_\_\_\_\_

If patient is not the insured, please complete the following:

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City Province Postal Code Phone

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**Secondary Dental Insurance (if applicable)**

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Group/Policy # \_\_\_\_\_ Division \_\_\_\_\_

ID/Certificate #: \_\_\_\_\_

If patient is not the insured, please complete the following:

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City Province Postal Code Phone