# Welcome to Our Office

We look forward to becoming partners in your dental health care. Our approach to dentistry is prevention oriented and is a team effort involving you and our staff. Together we will address any current dental concerns and endeavour to prevent future dental problems.

**Personal Information**

_____ _____ _____ _____

Title First Name Initial Last Name

Nickname: _____ Marital Status: _____ Sex: M☐ F☐ Date of Birth : ___/___/___ (DD/MM/YY)

Address: _____

Unit # _____ City: _____ Province: _____ Postal Code: _____

Home Phone #: _____ Business Phone # _____ Ext: _____

Cell #: _____ Email address: _____

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Employer: _____ Occupation: _____

Physician: _____ Phone #: _____

Pharmacist: _____ Phone #: _____

Former Dentist: _____ Phone #: _____

Who may we thank for inviting you to our practice? _____

Family member(s) in our practice: _____

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**Financial Information / Person responsible for financial matters:**

_____ _____ Relationship: _____ Date of Birth : ____/____/____

First Name Last Name (DD/MM/YY)

Home Phone #: _____ Business Phone # _____ Ext: _____

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**PRIMARY INSURANCE**

Subscriber: _____ _____ Date of Birth : ____/____/_____

First Name Last Name (DD/MM/YY)

Insurance Company: _____ Employer/ Policy Holder: _____

Policy or group #: _____ Certificate or ID #: _____ Division: _____

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**SECONDARY INSURANCE**

Subscriber: _____ _____ Date of Birth : ____/____/_____

First Name Last Name (DD/MM/YY)

Ins. Company:_____ Employer:_____ Policy #:_____ ID#:_____

**I consent to my physician being contacted, if necessary, as this information may be required for my dental care. I also assume responsibility for any fees associated with the dental services provided by Dr. Sungaila / Dr. Ong and staff.**

**I authorize release; to my dental 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 Dr. Sungaila / Dr. Ong. This authorization shall continue in effect until the undersigned revokes the same.**

**I hereby assign my benefits, payable from claims submitted electronically, to Dr. Sungaila / Dr. Ong and authorize payment directly to her.**

Signature of patient, parent or guardian: _____ Date:_____

If parent/guardian, please print name (First, Last):_____