Medical Alert:
Note:
A/c #
For office use only

WELCOME TO ROSSLAND /GARDEN DENTAL!

Please complete this form, if you have any questions please ask for help! ***PLEASE PRINT***

Today's Date: ____________ How did you find out about this office? _____________________________________
Day /Month/Year

Mr./Ms./Mrs./Dr.____
Patients: First Name Middle/Initial Last Name
Date of Birth: _______________ Health Card # ______________________
Day /Month/Year
Address: ____________________________ Unit#___ City: __________ Postal code: _________
Home Phone# _ _ _ _ _ _ _ _ _ _Bus. #_ _ _ _ _ _ _ _ _ _ Mobile# _ _ _ _ _ _ _ _ _ _
E-mail address: _________________
Emergency Contact: Name: _____________________ Relationship to patient: _______________
Home Phone # ________________ Bus. # _______________ Mobile#________________

Primary Person Responsible for this account: (*Please fill in applicable information*)
Mr./Ms./Mrs./Dr.____
First Name Middle/Initial Last Name
Date of Birth: ____________ Address: ____________________________ #______
Day/Month/Year Street Unit
City: _________ Postal code: _________Home # _ _ _ _ _ _ _ _ _ _Bus. #_ _ _ _ _ _ _ _ _ _ Mobile# _ _ _ _ _ _ _ _
_ _ E-mail address: _______________ Relationship to patient: ________
Insurance Co: ____________________ **Policy#**________________ **Cert.#** ________ **Div.**____
Employer: ______________________ **Address:** ______________________________________

Secondary Person Responsible for this account: (*Please fill in applicable information*)
Mr./Ms./Mrs./Dr.____
First Name Middle/Initial Last Name
Date of Birth: ____________ Address: ____________________________ #______
Day/Month/Year Street Unit
City: _________ Postal code: _________Home # _ _ _ _ _ _ _ _ _ _Bus. #_ _ _ _ _ _ _ _ _ _ Mobile# _ _ _ _ _ _ _ _
_ _ E-mail address: _______________ Relationship to patient: ________ **Insurance Co**: ____________________
Policy#_____________ **Cert.#** _______ **Div.**________
Employer: ______________________ **Address:** ______________________________________
____

We are pleased that you have selected our Dental Office. It is our wish that your dental health is the best that it can be and we will try our best to make it a reality. We request that payment for services are made at each appointment. If you have dental insurance and wish to assign your benefits to us, so that your insurance can pay us directly please sign below:(Please note that all fees not covered by your insurance are your responsibility)

I authorize release of information contained in claims submitted electronically to my dental benefits plan administrator and the CDA. I also authorize the communication of information related to the coverage of services described to Dr.Hattay and hereby assign my benefits, payable from claims submitted electronically, and authorize payment directly to Dr. Hattay. This authorization shall continue in effect until the undersigned revokes the same.

*Signature of patient, parent or gu*ardian: _________________________ *Date:* __________

Otherwise, payment is expected in full as treatment is done. Please select your method of payment:
□ *Cash* □ *Debit Card #:*________________________ *Bank:*_______________________________________
□ *Visa / Master Card/Other*____________*: #*______________________ *Expiry date:* ____/____

Signature of patient, parent or guardian: _________________________ *Date:* __________

Please turn the page over and complete the patient information and sign at the bottom. Thank you!