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

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# _ _ _ _ _ _ _ _ _ _ Mobile #_ _ _ _ _ _ _ _ _ _ Work # _ _ _ _ _ _ _ _ _ _
E-mail address: _____
Emergency Contact: Name: _____ Relationship to patient: _____
Home Phone # _____ Mobile # _____ Work #_____

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: _____ City: _____
Day/Month/Year Street Unit
Postal code: _____ Home # _ _ _ _ _ _ _ _ _ Mobile #_ _ _ _ _ _ _ _ _ _ Work # _ _ _ _ _ _ _ _
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 # _ _ _ _ _ _ _ _ _ _ Mobile #_ _ _ _ _ _ _ _ _ _ Work # _ _
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 guardian: _____ 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!