## PATIENT INFORMATION

**Patient Number:**

Name: _____ Date: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

City: _____ Cell Phone: _____

Province: _____ Postal Code: _____ E-Mail: _____

Date of Birth: _____ Employer: _____

AHC #: _____ Referred By: _____

## RESPONSIBLE PARTY (Please complete all information if different than above)

Name: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____

_____ Employer: _____

Date of Birth: _____ Work Phone: _____

## INSURANCE INFORMATION

Name of Insured: _____ Date of Birth: _____

Employer/Group Policy Holder: _____

Insurance Company: _____

Group/Individual Policy #: _____ Section #: _____ (if applicable)

I.D. #: _____

**DO YOU HAVE ANY ADDITIONAL INSURANCE?** ☐ YES ☐ NO *IF YES, COMPLETE THE FOLLOWING:*

Name of Insured: _____ Date of Birth: _____

Employer/Group Policy Holder: _____

Insurance Company: _____

Group/Individual Policy #: _____ Section #: _____ (if applicable)

I.D. #: _____

## PRIVACY CONSENT

| | | |
|---|---|---|
| I consent to the collection, use, and retention and disclosure of personal information as is required for my own dependants dental care. | X<br>Signature of patient | Date |