RICHMOND HILL
DENTAL DESIGN STUDIO

WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient #________________SS#/SIN______________ Date________________

PATIENT INFORMATION (CONFIDENTIAL)

Name____Birthdate____________ ___________

Address____City __________________State/Prov.______Zip/P.C__________

Email____Cell_______________________Home Phone____________________

Check Appropriate Box: • Minor • Single • Married • Divorced • Widowed • Separated

(Students Only)
Name of school/college______________________________City________________ State/Prov.______ • Full Time • Part Time

Patient or Parent/Guardian's Employer____Work Phone______________________

Business Address_______________________________________City __________________State/Prov.______Zip/P.C__________

Spouse or Parent/Guardian's Name____________________________Employer__________________Work Phone_____________

Whom may we thank for referring you?____

Person to contact in case of emergency____Phone____________________

RESPONSIBLE PARTY

Name____Relationship to patient__________________________

Address____City __________________State/Prov.______Zip/P.C__________

Email____Cell_______________________Home Phone____________________

Driver's License#_____________________________________Birthdate_____________Finnancial Institution________________

Employer____Work Phone______________________SS#/SIN__________________

Is this person currently a patient in our office? • Yes • No

We offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

• Cash Credit Card: • VISA • MasterCard • I wish to discuss the office's payment policy.

INSURANCE INFORMATION

Name____Relationship to patient__________________________

Birthdate_______________________________SS#/SIN _______________________Date Employed________________________

Name of Employer__________________________Union or Local#_________________Work Phone________________________

Address____City __________________State/Prov.______Zip/P.C__________

Insurance Company___________________________________Group#____________________Policy/ID#___________________

Ins. Co. Address_______________________________________City __________________State/Prov.______Zip/P.C__________

How much is your deductible?________________How much have you used?______________ Max. annual benefit____________

DO YOU HAVE ANY ADDITIONAL INSURANCE? • Yes • No **IF YES, COMPLETE THE FOLLOWING.**

Name of Insured____Relationship to patient_________________________

Birthdate_______________________________SS#/SIN _______________________Date Employed________________________

Name of Employer__________________________Union or Local#_________________Work Phone________________________

Address____City __________________State/Prov.______Zip/P.C__________

Insurance Company___________________________________Group#____________________Policy/ID#___________________

Ins. Co. Address_______________________________________City __________________State/Prov.______Zip/P.C__________

How much is your deductible?________________How much have you used?______________ Max. annual benefit____________

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