

PATIENT INFORMATION FORM

Welcome to My Dental Home. We are glad you are here. Should you have any questions please feel free contact us at mydentalhome@rogers.com or 905-415-7700.

NAME: _____ PREFERRED NAME: _____

ADDRESS: _____

CITY: _____ PROV.: _____ POSTAL CODE: _____

HOME PHONE: _____ BUS. PH: _____ CELL: _____

EMAIL: _____

DATE OF BIRTH: _____ SIN#: _____ DRIVER'S LIC: _____
MM/DD/YY

PERSON RESPONSIBLE FOR ACCOUNT: _____

EMPLOYED BY: _____

NAME OF SCHOOL(if student): _____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

IN CASE OF AN EMERGENCY PLEASE CONTACT:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

DENTAL BENEFITS INFORMATION

POLICY HOLDER: _____ DATE OF BIRTH: _____

EMPLOYER NAME: _____ SIN: _____

INSURANCE CARRIER: _____

POLICY/GROUP #: _____ CERTIFICATE #: _____

ARE YOU COVERED BY ANY OTHER DENTAL BENEFITS? Yes/No

POLICY HOLDER: _____ DATE OF BIRTH: _____

EMPLOYER NAME: _____ SIN: _____

INSURANCE CARRIER: _____

POLICY/GROUP #: _____ CERTIFICATE #: _____

I AUTHORIZE RELEASE TO MY INSURANCE COMPANY/PLAN ADMINISTRATOR, THE INFORMATION CONTAINED IN CLAIMS SUBMITTED ELECTRONICALLY.

Signed

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