Lakeridge Dental

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PATIENT REGISTRATION FORM(CONFIDENTIAL)

NAME _____ CURRENT DATE_____
ADDRESS_____ CITY, PROVINCE_____ POSTAL CODE_____
HOME PHONE_____ E-MAIL_____ CELL #_____
WORK PHONE _____ EMPLOYER _____ OHIP _____
DATE OF BIRTH _____ AGE _____ SEX _____ MARITAL STATUS _____
PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____
IF STUDENT, NAME OF SCHOOL _____ GRADE _____
WHOM MAY WE THANK FOR REFERRING YOU _____

RESPONSIBLE PARTY (PLEASE COMPLETE ALL INFORMATION IF DIFFERENT FROM ABOVE)

NAME_____ RELATION TO PATIENT_____
ADDRESS _____ HOME PHONE_____
DRIVER'S LICENSE # _____ DATE OF BIRTH_____
EMPLOYER _____ WORK PHONE _____
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ DATE OF BIRTH_____
EMPLOYER/GROUP POLICY HOLDER_____ INSUREANCE YEAR END_____
INSURANCE COMPANY_____ PHONE_____
GROUP/INDIVIDUAL POLICY # _____ CERTIFICATE # _____
I.D./S.I.N. _____ MAXIMUM COVERAGE _____ %USED _____
PERCENTAGE COVERAGE: BASIC _____ MAJ. REST. _____ ORTHO_____

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

NAME OF INSURED _____ DATE OF BIRTH_____
EMPLOYER/GROUP POLICY HOLDER_____ INSUREANCE YEAR END_____
INSURANCE COMPANY_____ PHONE_____
GROUP/INDIVIDUAL POLICY # _____ CERTIFICATE # _____
I.D./S.I.N. _____ MAXIMUM COVERAGE _____ %USED _____
PERCENTAGE COVERAGE: BASIC _____ MAJ. REST. _____ ORTHO_____

SIGNATURE OF PATIENT OR PARENT IF MINOR _____