Original Office Site: ☐ NF ☐ WELLAND ☐ ST. CATH

Maxident ID#:________________
Alternate ID #: ________________

PATIENT INFORMATION: ☐ Mr. ☐ Dr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Mstr.

Name: ____
LAST FIRST MIDDLE

Address: ____
NUMBER & ST. APT# CITY PROVINCE POSTAL CODE

Primary # (_____) ______________________ Alternate # Cell ☐ Work ☐ (_____) ______________

Health Card # __________________________Version Code: _______exp date: ________________
Month/ Day/ Year

Date of Birth: ________________________ Age: _____________ Gender: M ☐ F ☐ Unknown ☐
Month/ Day / Year

Student: ☐ NO ☐ YES Name of School: ____
Email address: (optional): ____
Have you ever been a patient in our practice? ☐ Yes ☐No

Family Dentist: _______________Family Doctor: _______________ Referred by: _______________

Who will be responsible for your account: ☐Self (skip this section) ☐Spouse ☐ Parent ☐ Other

Name: ____
Last First
Address:____Phone # :______________
Number & Street Apt # City Prov. Postal Code

Do you have any dental insurance? ☐ No ☐Yes ☐ Ontario Works ☐ ODSP ☐ HSO

Primary Insurance:

Name of Insured: ________________________

DOB: ________________________

Employer: ________________________

Insurance Company: ________________________

Group #________________________

ID# ________________________

Secondary Insurance:

Name of Insured: ________________________

DOB: ________________________

Employer: ________________________

Insurance Company: ________________________

Group #________________________

ID# ________________________

Please sign below ONLY if you have dental insurance:
I authorize release, to my insurance company plan administrator, the information contained in claims submitted electronically and hereby assign my benefits payable from claims submitted electronically to Drs. Carriero/ Gervais/Bosco /Taliano and authorize payment directly them.

____
X (Signature of Subscriber, parent or guardian)

PAYMENTS ARE REQUIRED UPON COMPLETION OF TREATMENT.
VISA, M/C, INTERAC AND CASH ARE ACCEPTED. Rev Sept 2021