DOWSETT
DENTAL HEALTH

Patient Information

Patient Name: _____ Gender:_____ Date: _____
Last, First MI (Preferred Name) M/F

Birth Date:_____ Family Status:_____ Email Address:_____
(dd/mm/yyyy) Married/Single/Child

Phone (Home): _____ (Cell):_____ (Work): _____ ext._____

Address: _____
Street Apartment #

_____
City Province Postal Code

Emergency Contact Information

Whom may we contact in case of emergency?

1. Name_____ Phone._____ Relationship_____

2. Name_____ Phone._____ Relationship_____

Referral Information

How did you hear about us? ☐ Another patient ☐ Blue Cross ☐ UofC/SAIT/MRC ☐ Dental Office ☐ Denturist

☐ Yellow Pages ☐ Internet ☐ Advertisement ☐ Other _____

Name of person or office we may thank for referring you to our practice: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes☐ No☐
Last First MI

Insured's Birth Date: _____ Insured's Address: _____
Street City Province Postal Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Common Law Other _____

Insurance Plan Name:_____Group#_____Cert/ID#_____

Secondary

Name of Insured: _____ Is insured a patient? Yes☐ No☐
Last First MI

Insured's Birth Date: _____ Insured's Address: _____
Street City Province Postal Code

Insured's Employer Name: _____

Patient's relationship to insured: Self☐ Spouse☐ Child☐ Common Law☐ Other _____

Insurance Plan Name:_____Group#_____Cert/ID#_____