PRINCESS DENTAL

- Dr. Geoff McIntosh
- Dr. Jill Gudmandson
- Dr. Nathan Vercaigne
- Dr. Jessica Carswell
- Dr. Erica Seebach

PATIENT INFORMATION (Confidential)

First Name _____ Last Name _____ Birth date _____

Address _____ City _____ Prov _____ Postal Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Marital Status _____

E-mail _____ Gender _____

Previous Dental Office _____ Office Phone Number _____

Emergency Contact/Parent Contact _____ Phone # _____

How did you hear about us? _____

If you selected Family/Friend or other, whom shall we thank for your referral? _____

Serving you to the best of our ability is our top priority. Please help us understand what your needs and expectations are:

- ☐ Exam and Cleaning
- ☐ Basic Dentistry
- ☐ Invisalign
- ☐ Implants
- ☐ Implant Dentures
- ☐ Sedation
- ☐ Esthetics/Smile Make-over
- ☐ Single Area of Concern
- ☐ Multiple Areas of Concern
- ☐ Other _____

PRIMARY INSURANCE POLICY

Insurance Company _____ Policy # _____

Sub ID # _____

Policyholder's Name _____

Policyholder's Date of Birth _____

Place of Employment _____ Work Phone _____

Please select your insurance provider:

- ☐ Blue Cross
- ☐ Canada Life
- ☐ Sunlife
- ☐ Greenshield
- ☐ Manulife
- ☐ Chamber of Commerce
- ☐ Claim Secure
- ☐ Co-operators
- ☐ Coughlin
- ☐ NHIB
- ☐ Employment Income Assistance
- ☐ Other _____

SECONDARY INSURANCE POLICY

Insurance Company _____ Policy # _____

Sub ID # _____

Policyholder's Name _____

Policyholder's Date of Birth _____

Place of Employment _____ Work Phone _____

Please select your insurance provider:

- ☐ Blue Cross
- ☐ Canada Life
- ☐ Sunlife
- ☐ Greenshield
- ☐ Manulife
- ☐ Chamber of Commerce
- ☐ Claim Secure
- ☐ Co-operators
- ☐ Coughlin
- ☐ NHIB
- ☐ Employment Income Assistance
- ☐ Other _____

CREDIT CARD AUTHORIZATION

Our office will gladly direct bill your insurance company on your behalf. In order to direct bill your insurance company, we kindly ask that you leave an imprint of your credit card and any amounts not covered by your insurance company will be charged to your credit card and an email receipt sent. Please advise us of any future changes in your credit card. I authorize Princess Dental Centre to process invoice charges to my:

☐ Visa ☐ Mastercard (Debit/Visa or Debit credit cards are not accepted)

Credit Card # _____CCV# _____ Expiry Date _____

Patient(s) on Account:

_____

Name(s) of Patient That The Credit Card is Authorized For:

_____

Cardholder First Name _____

Last Name _____

Cardholder E-mail Address:

_____

Cardholder Signature _____Date _____

The balance remaining after we have received your insurance benefits, will be charged to your credit card. This authorization will be in effect until notice of cancellation is forwarded in writing to Princess Dental Centre.

CONSENT FOR SERVICES

I, the undersigned, I agree to pay value of said services which shall be as billed, unless objected to by me, in writing, within the time for payment thereof. I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand my personal information disclosed is protected by the Privacy Act. I agree that Princess Dental Centre can electronically file dental claims on my behalf.

I have read the above conditions of treatment and payment and agree to their content.

Signature _____ Date _____

(Patient, Parent, or Guardian)