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Please fill out the form below

	1	Initial		First Name	
Address			City	Postal	
Home Tel		Cell		Work	
Tione (e)	,	:00		4.014	
Date of Birth: DD/MM/YYYY			Email Address		
Emergency Contact			Phone		
How did you hear about us?			Health Card #		
Do you have dental insurance?			If Yes complete the following	1	
Primary Insurance					
Company			Policy Holder		
Policy/Plan/Group			Certificate/LD		
Policy holders Date of Birth DD/MM/YYYY					
Policy holders Date of Birth DD/	/MM/YYYY		Relation to Holder		
Secondary Insurance					
Company			Policy Holder		
Policy/Plan/Group			Certificate/LD.		
Policy holders Date of Birth DD/	/MM/YYYY		Relation to Holder		
Has there been any change in	your general health?				O Yes O No
If YES please describe					
Are you being treated for any m	nedical condition or have w	ou been treated within the n	past 2 years?		O Yes O No
	That of have y	pared within the p			
If YES please describe					
Are you currently being treated	l by a physician for a specif	fic condition?			O Yes O No
If YES please describe					
Are your currently taking any m	nedication?				
Medication					Dose
Medication					Dose
70X 64 1701					
Medication					Dose
Do you bleed or bruise easily?					O Yes O No
Have you ever been hospitalize	ed?				Yes No
If YES please describe					
If YES please describe Have you ever received general	al anesthesia?				O Yes O No
	CONTRACTOR CONTRACTOR AND RANKS AND	c?			O Yes O No
Have you ever received genera	e reaction to local anesthetic	c?			
Have you ever received general Have you ever had an adverse Do you have any allergies to m	e reaction to local anesthetic	c?			⊚ Yes ⊚ No
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I the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I will

assume full responsibility for the fees associated with these procedures. I agree to the privacy policies posted in the reception area and consent to the electronic sharing of information with my insurance company for the purpose of processing insurance claims and determination of benefits. Unless other arrangements have been made assignment of benefits from your insurance company will be set up. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and my dentist. I authorize the dentist to treat me and I assume full responsibility for all fees. I am aware that 2 business days notice is required to change or cancel an appointment without charge.

SIGNATURE (PARENT OR GUARDIAN IF UNDER 16)

To be signed at your appointment