Welcome to Our Office

We look forward to becoming partners in your dental health care. Our approach to dentistry is prevention oriented and is a team effort involving you and our staff. Together we will address any current dental concerns and endeavour to prevent future dental problems.

Personal Information

_____ ______________________________ _____ ______________________________________
Title First Name Initial Last Name

Nickname: ________________ Marital Status: ___________ Sex: M☐ F☐ Date of Birth : ___/___/___ (DD/MM/YY)

Address: ____

Unit # ____________ City: ___________________ Province: _______ Postal Code: ______________

Home Phone #: _______________________ Business Phone # _______________________ Ext: ________

Cell #: _________________________ Email address: ______________________________________

Employer: _____________________________________ Occupation: ___________________________________

Physician: _____________________________________ Phone #: _____________________________________

Pharmacist: ____________________________________ Phone #: _____________________________________

Former Dentist: _________________________________ Phone #: _____________________________________

Who may we thank for inviting you to our practice? ____

Family member(s) in our practice: ____

Financial Information / Person responsible for financial matters:

_________________ ___________________ Relationship: ____________ Date of Birth : ____/ ____/____
First Name Last Name (DD/MM/YY)

Home Phone #: ___________________ Business Phone # _________________________ Ext: _________

PRIMARY INSURANCE

Subscriber: ________________________ _____________________________ Date of Birth : ____/ ____/ _____
First Name Last Name (DD/MM/YY)

Insurance Company: ______________________________ Employer/ Policy Holder: ________________________

Policy or group #: ________________ Certificate or ID #: ________________________ Division: _______

SECONDARY INSURANCE

Subscriber: ________________________ _________________________ Date of Birth : ____/ ____/ _____
First Name Last Name (DD/MM/YY)

Ins. Company:_________________ Employer:________________ Policy #:___________ ID#:________________

I consent to my physician being contacted, if necessary, as this information may be required for my dental care. I also assume responsibility for any fees associated with the dental services provided by Dr. Sungaila / Dr. Ong and staff.

I authorize release; to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to Dr. Sungaila / Dr. Ong. This authorization shall continue in effect until the undersigned revokes the same.

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Sungaila / Dr. Ong and authorize payment directly to her.

Signature of patient, parent or guardian: ____________________________________ Date:__________________

If parent/guardian, please print name (First, Last):____

9th Line DENTAL