Special Concerns:

Are you nervous about dental treatment? ☐ no ☐ yes _____
Would you like more information on tooth whitening? ☐ no ☐ yes _____
Would you like more information on braces? ☐ no ☐ yes _____
Are you aware of night time tooth grinding? ☐ no ☐ yes _____
Do you require a sports mouth guard? ☐ no ☐ yes _____

If someone else is responsible for your account please fill out this box,

Name of Person Responsible for Account: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____
Birth Date: _____
Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____
Address: _____
Street Apartment #
_____
City Province Postal Code

Insurance Holder's Information

Primary Insurance Plan
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #:_____
Insured's Address: (if different from patient's Address)
_____
Street City Province Postal Code
Insured's Employer Name: _____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insurance Plan Name:_____

Secondary Insurance Plan
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #:_____
Insured's Address: (if different from patient's Address)
_____
Street City Province Postal Code
Insured's Employer Name: _____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insurance Plan Name:_____

Please initial all applicable items:

___ I authorize release, to my insuring company plan administrator and CDA, the information contained in claims submitted electronically.
___ I hereby assign my benefits payable from claims submitted electronically or by mail to Dr. O. Rohn, Dr. S. Family, Dr. R. Bhatti, Dr. J. Yu, Dr. M. Dosanjh, Dr. A. Sajan, Dr. M. Khan, Dr. I. Shoval, Dr. Sina Makaremi, Dr. Anny Charolia, Dr. Larissa Briante and authorize payment directly to him/her.
___ To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Financial Policies

Your insurance benefits are between you, your employer and your insurance company. Any benefit difference (deductible, fee guide, ineligible service or co-payment) is your responsibility. A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. All estimates for care approximate.

PIPEDA

____I acknowledge that I have been shown the office privacy policy and I understand that any information collected about me will be used only for the purposes for which it was collected and will never be shared with a third party without my consent.

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

_____ Date: _____ Relationship to Patient:_____
Signature of patient, parent, guardian, or guarantor of payments

_____
Printed Name of patient, parent, guardian, or guarantor of payments