West Lake Dental Group Centre Patient Registration

Personal Information

◉ Mr. ○ Mrs. ○ Miss ○ Ms

First Name: **Initial**: **Last Name:**

Address

No.: **Street Name:** **Apt No.**

City: **Province:** **Postal Code**

Home Phone No.: _____**Business/Work No.:** _____ **Mobile No.:** _____

Email Address: _____

Date of Birth: ____/ _____/ _____ **Driver's License No.:** _____
D M Y

Emergency Contact Name: _____ **Relationship**:_____

Phone No.: _____

Are family members patients at our office? ☐ yes Names:_____

Whom may we thank for referring you? _____

I prefer to be contacted**:** ☐ at home ☐ at work ☐ mobile ☐ by email ☐ no preference

Financial and Insurance Information

At West Lake Dental Group payment is due when services are rendered. If you have dental insurance we will submit the claim on your behalf. We accept Visa, MasterCard, Debit, Cheques and Cash as method of payment. Our fees are based on the ODA Fee Guide for the current year, however some services are charged slightly above the suggested fee. If you have any questions regarding our fees, please inquire.

Person responsible for your account:

☐ self ☐ parent/guardian ☐ spouse ☐ other: _____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Subscriber:	Subscriber:
Date of Birth:	Date of Birth:
Insurance Co:	Insurance Co:
Policy #:	Policy #:
ID#:	ID#:
Employer:	Employer:

I, the undersigned, state that I have completed all information forms accurately, without knowingly omitting any information. On the basis of confidentiality, I hereby consent to the release and transfer of any patient information and dental records within my file for dental insurance purposes including submitting dental claims or pre-determinations or for any inter-practitioner communication. I agree that West Lake Dental Group has obtained informed consent from me with respect to the collection, use, and disclosure of my personal health information. If asked, I will be provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection Act, 2004.

Signature:_____ Date:_____
Patient or Parent/Guardian