Welcome to The Waterdown Denture Clinic!

Date: _____

Mr. / Mrs. / Ms. **First Name**: _____ **Last Name**: _____

Birth Date (DD/MM/YYYY): _____

Address: _____

City, Province, Postal Code: _____

Phone: (____) - _____ - _____ Cell Phone: (____) - _____ - _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: (____) - _____ - _____ Cell Phone: (____) - _____ - _____

E-mail Address: _____

How did you hear about our office?

□ Yellow Pages Book □ Yellow Pages Online □ Dentist _____ □ Friend _____

□ Family _____ □ Newspaper □ Street Sign □ Website/Internet □ Church Bulletin

□ Flyer □ Visit to Service Ontario □ Other: _____

Do you have **Dental Insurance** coverage? ___ **Yes** ___ **No**

INSURANCE INFORMATION (if applicable)

Name of Insured: _____ **Birth Date** (DD/MM/YYYY): _____

Relationship to patient: □ Self □ Spouse □ Other: _____

Insurance Company: _____ Employer: _____

Policy/Group #: _____ I.D./ Certificate #: _____

Co-Insured name: (if applicable) _____ **Birthdate** (DD/MM/YYYY):_____

Insurance Company**:** _____ _____ Employer: _____

Policy/Group #: _____ I.D./ Certificate #: _____

I give permission for all services rendered at R. Kulik Waterdown Denture Clinic to be submitted and claimed using the above insurance information

PRIVACY POLICY

Raymond Kulik Denture Clinic will only collect information needed to serve patient needs and will maintain the privacy and security of the information in accordance with its Privacy Policy (posted) as well as the Personal Protection Act.

PATIENT'S SIGNATURE