

Welcome to Waterdown Denture Clinic

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

Birth Date (DD/MM/YYYY): _____

Address: _____

City, Province, Postal Code: _____

Primary Phone: (____) - ____ - ____ **Secondary Phone:** (____) - ____ - ____

▶▶ **E-mail Address:** _____

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

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

How did you hear about our office? *NEW PATIENTS ONLY*

- Dental Office/ Dr. _____ Website/ Internet Friend / Family _____
 Glen Echo Newsletter Street Sign Church Bulletin Yellow Pages
 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

Date: _____