Welcome to Waterdown Denture Clinic

Please complete the following information so we can provide you with the best care possible.

Patient Information

Full Name: _____

Date of Birth (DD/MM/YYYY): ____ / ____ / _____

Address: _____

City, Province, Postal Code: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Who referred you to our clinic? _____

Do you have dental insurance coverage? [ ] Yes [ ] No [ ] CDCP

Insurance Information (if applicable)

Name of Insured:	Co-Insured Name (if applicable):
Date of Birth (DD/MM/YYYY): ___ / ___ / _____	Date of Birth (DD/MM/YYYY): ___ / ___ / _____
Relationship to Patient: [ ] Self [ ] Spouse [ ] Other:	Relationship to Patient: [ ] Self [ ] Spouse [ ] Other:
Insurance Company:	Insurance Company:
Policy/Group #:	Policy/Group #:
Certificate / I.D. #:	Certificate / I.D. #:

I authorize the submission of claims to my insurance provider for services rendered at Waterdown Denture Clinic.

Privacy Policy

We are committed to protecting your privacy. The information you provide is used solely for the purpose of your care and is safeguarded according to our Privacy Policy and the Personal Information Protection and Electronic Documents Act (PIPEDA).

Patient Signature: _____ Date: _____