



Essex Dental Centre

Patient Registration Form:

Dr. Mr. Mrs. Ms. Miss.

Name: _____
first middle last

Date of Birth: _____ Age: _____
mm/dd/yyyy

Address: _____
street city province postal code

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

Email: _____

In the future, may we confirm your appointments by email? *Y or N*

Employer Name _____ Employer Phone Number (____) _____

Family Physician _____ Physician Phone Number (____) _____

Your Spouse's Name _____

Your Spouse's Employer _____ Spouse's Employer Phone No. (____) _____

Emergency Contact

Name: _____ Phone: (____) _____ Relation: _____

HOW DID YOU HEAR ABOUT US? (Referral) _____

Child Registration Form:

Name: _____

Date of Birth: _____ Age: _____
first middle last mm/dd/yyyy

School: _____ Grade: _____

check if same as above

Address: _____
street city province postal code

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

Is another family member a patient here at our office? *Y or N If yes,*

Name _____

Insurance Information

<i>Primary Coverage</i>	<i>Secondary Coverage</i>
Name of Insured _____	Name of Insured _____
Birthdate of Insured _____	Birthdate of Insured _____
Primary Insurance Carrier _____	Secondary Insurance Carrier _____
Group/Policy Number _____	Secondary Group/Policy Number _____
I.D. Number _____	Secondary I.D. Number _____
Division Number _____	Secondary Division Number _____

x _____ (Signature of Patient/or Guardian) _____ (date)

x _____ (Print name of Guardian)