KING
DENTAL CENTRE

PATIENT REGISTRATION

Patient Name: ______________________ ☐ Adult ☐ Child Date of Birth: __________

PATIENT INFORMATION

Marital Status:
☐ Single ☐ Married ☐ Common-Law ☐ Other

Spouse/Partner's Name: ______________________

Address: ______________________

City: ______________Postal Code: __________

Occupation: ______________________

Do you have family members or friends that are patients of this office?
☐ Yes ☐ No ______________________

Referred by: ______________________

Health Card # ______________________

CONTACT INFORMATION

Home Phone: ______________________

Work Phone: ______________________

Cell Phone: ______________________

E-mail Address: ______________________

Please indicate the best time to contact you for appointments:
☐ Any Time/Any Day ☐ Days Only
☐ Evenings Only ☐ Weekends

Preference for method of contact: ☐ Phone ☐ E-mail ☐ Text

In case of an emergency, contact:

Name:______________________

Relationship:______________ Phone: __________

RESPONSIBLE PARTY

☐ Self ☐ *Spouse ☐ *Other ______________
*Please complete information below

Name: ______________________

Address: ______________________

City: ______________ Postal Code: __________

Employer: ______________________

Phone: Home ______________ Work______________

Is this person currently a patient at our office? ☐ Yes ☐ No

DENTAL INSURANCE (PRIMARY COVERAGE)

Employee Name: ______________________

Employee Date of Birth: ______________________

Employer: ______________________

Insurance Company: ______________________

Group Policy No. ______________________

Certificate or ID No. ______________________

DENTAL INSURANCE (ADDITIONAL COVERAGE)

Employee Name: ______________________

Employee Date of Birth: ______________________

Employer: ______________________

Insurance Company: ______________________

Group Policy No. ______________________

Certificate or ID No. ______________________

PAYMENT INFORMATION

Coverage:

Basic__________% Ortho__________%

Major__________% Endo__________%

Other__________% Perio__________%

Maximum Coverage ______________________

Check-up Frequency: Every ________ Months

(Please see reverse)

INFORMED CONSENT

GENERAL RELEASE

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
- I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand that my dental care insurance company may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.
- I authorize the setting up of my dental file, its follow-up, as well as my registration on the recall list(s) of the treating dentist(s).
- I have been informed that my file will be kept in the office at all times and that only the dentist(s) and his/her (their) auxiliary personnel will have access to it.
- I attest to the accuracy of the information on this registration form.

Signature of Patient or Parent/Guardian____Date_______________________________

MEDICAL/DENTAL INFORMED CONSENT

- I, the undersigned, certify that I have provided, to the best of my knowledge, an accurate and complete medical & dental history and have not knowingly omitted any information. I consent to my dentist obtaining from other practitioner who are currently treating me or have treated me, such further information as maybe necessary for providing me with proper dental treatment and care. I herby promise to inform my dentist of any changes to my health status.

Signature of Patient or Parent/Guardian____Date_______________________________

SIGNATURE ON FILE

- I authorize release to my insuring company(s) plan administrator() the information contained in claims submitted electronically.
- I herby assign my benefits payable from claims submitted electronically to Dr. ____ and authorize payment directly to him/her.

Signature of Patient or Parent/Guardian____Date_______________________________