FOREST GLADE
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:_____
first *middle* *last*
Date of Birth: _____ Age: ____
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

Primary Coverage	***Secondary Coverage***
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)*