Welcome to Marquis Dental Group:

Your answers are important. Please help us to diagnose conditions completely, so that we may give you the safest treatment and the most personal attention. All information is confidential.

PATIENT INFORMATION

Name: _____
LAST FIRST MIDDLE INITIAL

(if child) Parent / Guardian: _____

Gender: ☐ M ☐ F ☐ Other _____ ☐ Decline to Answer

Address: _____
POSTAL CODE

Birthdate: _____ Phone: (cell) _____ (home) _____
MONTH / DAY / YEAR

Phone: (work) _____ Email Address: _____

Occupation: _____

Employer: _____

Preferred method of communication ☐ Phone ☐ Email ☐ Text

Who may we thank for referring you to our office? _____

Emergency Contact: _____ Emergency Contact Number: _____

INSURANCE

Does the following apply? Please check (✓)

☐ Indian Affairs – DIAND # _____

☐ Social Services – Sask. Hosp. # _____

☐ Veteran Affairs – Coverage # _____

☐ Dental Insurance – Insuring Company's Name: _____

Name of Insurance Policy Holder _____ Birthdate of Policy Holder _____

Group Policy # _____ Subscriber # _____

For your convenience, we accept Personal Cheques, VISA, MasterCard & Interac. Payment is expected the day services are rendered unless other arrangements have been made in advance.

DENTAL HISTORY

1. Approximate date of your last dental appointment: _____

   by Dr. _____ City: _____

2. Do you have trouble with local anaesthetic (freezing)? Yes ☐ No ☐
3. Have you been treated by an orthodontist, endodontist, periodontist and / or oral surgeon? Yes ☐ No ☐
4. Are you nervous during dental treatment? Yes ☐ No ☐ Not Sure ☐

PATIENT CERTIFICATION AND CONSENT

I, the undersigned certify that all of the personal, medical and dental information is true to my knowledge and I have not omitted any pertinent information. I consent to the performing of dental procedures mutually agreed to be necessary including the use of local anaesthetics as indicated and I will assume responsibility for fees associated with these procedures. I consent to the collection, use and disclosure of my personal information to enable proper communication and provision of my dental health services, to obtain payment of my account and for the uses, purposes and disclosures described in the Privacy Policy.

Patient (Parent/Guardian)
Signature: _____ Date: _____

(over) →