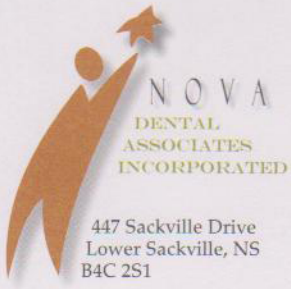

447 Sackville Drive
Lower Sackville, NS
B4C 2S1

How did you hear about our office? _____

Name: _____
Surname First Middle Initial Preferred

Birth Date: _____ Provincial Health Card Number: _____
Month Day Year

Address: _____
Street City Postal Code

Home Phone: _____ Work Number: _____ Cell Number: _____

Email: _____

Emergency Contact: _____ Relationship: _____

Insurance and Financial Information:

Insurance Information: ☐ Yes ☐ No

Insurance Company: _____

Subscriber (Plan Holder): _____ Relation: _____ Subscriber's Date of Birth: _____

Policy/Plan Number: _____ Certificate/ID Number: _____

Employer: _____ SIN Number: _____

Consent for Services:

As a condition of your treatment by this office, financial arrangements must be made in advance. I consent to the performing of dental procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with these procedures.

It is the responsibility of the patient to understand what procedures are (are not) covered by your dental insurance, as you are ultimately responsible for the payment of all procedures performed. As a courtesy, we will submit claims directly to your insurance carrier on your behalf. Payment of any portion not covered by insurance is due at the time of treatment.

I certify that I have read the contents of this form.

Signature: _____ **Date:** _____

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 2 business days notice. Short notice cancellations and "no shows" will be charged for time lost.