

Personal Information

Mr. Mrs. Miss Ms

First Name: _____ **Initial:** _____ **Last Name:** _____

Address

No.: _____ **Street Name:** _____ **Apt No.** _____

City: _____ **Province:** _____ **Postal Code** _____

Home Phone No.: _____ **Business/Work No.:** _____ **Mobile No.:** _____

Email Address: _____

Date of Birth: ___/___/___ **Driver's License No.:** _____
 D M Y

Emergency Contact Name: _____ **Relationship:** _____

Phone No.: _____

Are family members patients at our office? yes Names: _____

Whom may we thank for referring you? _____

I prefer to be contacted: at home at work mobile by email no preference

Financial and Insurance Information

At Innovation Drive Dental payment is due when services are rendered. If you have dental insurance we will submit the claim on your behalf and accept reimbursement from your insurance directly according to your policy specifications. Our office policy requires any insurance differences or services not covered to be paid by the patient on the day of the appointment. Our fees are based on the ODA Fee Guide for the current year. We accept Visa, MasterCard, Debit, Cheques and Cash. If you have any questions regarding our fees, please inquire.

Person responsible for your account:

self parent/guardian spouse other: _____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Subscriber:	Subscriber:
Date of Birth:	Date of Birth:
Insurance Co:	Insurance Co:
Policy #:	Policy #:
ID#:	ID#:
Employer:	Employer:

I, the undersigned, state that I have completed all information forms accurately, without knowingly omitting any information. On the basis of confidentiality, I hereby consent to the release and transfer of any patient information and dental records within my file for dental insurance purposes including submitting dental claims or pre-determinations or for any inter-practitioner communication. I agree that Innovation Drive Dental has obtained informed consent from me with respect to the collection, use, and disclosure of my personal health information. Please note that personal information used, disclosed, secured or retained by Innovation Drive Dental will be held solely for the purposes for which we collected it and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act.

Signature: _____ Date: _____
 Patient or Parent/Guardian