



Patient Information

Today's Date: _____

Given Name: _____ Mr/Mrs/Ms/Dr/Child

Preferred Name: _____
First Last Male Female

Birthdate: ____/____/____ Age: _____
D M Y

Home Address: _____

City Province Postal Code

Home #: _____ Work #: _____

Cell #: _____ Email: _____ (email and/or cell # will be used for appointment reminders/Clinic Updates and will not be shared with third party unless we refer you to a Specialist)

Occupation: _____

How did you hear about us? (Please circle one)

- Internet Sign Friend's Family
 Other _____

Previous/Current Dentist: _____

Date of last Dental Visit: _____

Person responsible for account (please circle one):

- Self Parent Other