

Smile Elements Orthodontics | Personal Information

Please assist us to provide you with the optimum care by answering every applicable question on this form. All information on this form will be kept confidential. Thank you.

PATIENT PERSONAL INFORMATION: (Circle) Dr. Mr. Mrs. Ms. Miss. Mster.

Name: Last _____ First _____ Middle _____

Preferred Name: _____ Birthdate (DD/MM/YY): _____ / _____ / _____

Home Address: _____ City: _____

Province: _____ Postal Code: _____ eMail: _____

Phone Numbers: Home _____ Work _____ Cell _____ Other _____

EMPLOYER: _____

IF PATIENT IS A MINOR:

Father's Information:

Name: Last _____ First _____ Middle _____

Address (If different from above): _____

City: _____ Province: _____ Postal code: _____ eMail: _____

Phone Numbers: Home _____ Work _____ Cell _____ Other _____

Mother's Information:

Name: Last _____ First _____ Middle _____

Address (If different from above): _____

City: _____ Province: _____ Postal code: _____ eMail: _____

Phone Numbers: Home _____ Work _____ Cell _____ Other _____

WHO CAN WE THANK FOR REFERRING YOU TO OUR CLINIC?

DENTAL INSURANCE INFORMATION

Primary Carrier

Insurance Company Name: _____

Employer Name: _____

Subscriber Name (policy holder): _____ Birthdate (DD/MM/YY): _____ / _____ / _____

Group (policy) Number: _____ Division Number: _____ Certificate/Employee Number: _____

Secondary Carrier

Insurance company Name: _____

Employer Name: _____

Subscriber Name (policy holder): _____ Birthdate (DD/MM/YY): _____ / _____ / _____

Group (policy) Number: _____ Division Number: _____ Certificate/Employee Number: _____