First name:_____ **Last name:**_____ **Preferred Name:** _____

Mr.__ Mrs.__ Ms. __ Miss.__ Mstr.__ Dr.__ **Date of birth:**_____

Mailing address:_____

City:_____**Postal code:**_____

Home phone:_____**Cell:**_____**Work:**_____

Email address:_____

Yes, please send appointment confirmations: by text ☐ by email ☐
Yes, please send check up reminders: by text ☐ by email ☐
Yes, please send statements by email ☐

Emergency contact:_____ **Number:**_____
Medical Doctor:_____ **BC Care Card:** _____
Previous Dentist: _____ **Referred by:**_____

Are you interest in more information about any of our in-office services?
Whitening ☐ Cosmetic Dentistry ☐ Dental Hygiene ☐ Dental Implants ☐
Invisalign ☐ Sleep Apnea ☐ Night Guard ☐ Orthodontics ☐

Signature:_____ **Date:** _____

INSURANCE INFORMATION

Primary Insurance: _____ **Card Holder**_____

DOB: Month_____**Day**_____**Year**_____ **Employer** _____

Group/Policy # _____**ID#**_____**Dependant#**_____

Secondary Insurance:_____**Card Holder**_____

DOB: Month_____**Day**_____**Year**_____ **Employer** _____

Group/Policy # _____**ID#**_____**Dependant#**_____