



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 or by email

Yes, please send check up reminders: by text or by email

Yes, please send statements by email

Emergency contact: _____ Number: _____

Medical Doctor: _____ BC Care Card: _____

Previous Dentist: _____ Referred by: _____

Are you interested in more information about any of our in-office services?

Whitening Cosmetic Dentistry Dental Hygiene Dental Implants

Invisalign Sleep Apnea Night Guard Orthodontics

INSURANCE INFORMATION

Primary Insurance: _____ Card Holder _____

DOB: Month _____ Day _____ Year _____ Employer _____

Group/Policy # _____ ID# _____

Secondary Insurance: _____ Card Holder _____

DOB: Month _____ Day _____ Year _____ Employer _____

Group/Policy # _____ ID# _____

Signature: _____

Date: _____