Welcome to Our Office
ON TRACK DENTAL

Name:_____ _____ Birthdate: M:_____D: _____Y: _____
LAST FIRST

Address:_____ _____ _____ _____ _____
UNIT # STREET # CITY PROV POSTAL CODE

Home Phone: _____ Cell: _____ Work: _____

E-Mail: _____ CARECARD #_____ Employer:_____

Driver License: _____ *SIN: _____

If you wish to put on file: Credit Card: _____ EXP: ___/___ 3 Digit Security #: _____

Emergency contact: _____ Phone #: _____

How did you hear about us? ❑ Internet ❑ Newspaper Patient / Other:_____

PRIMARY INSURANCE

_____

SECONDARY INSURANCE

_____

Please Initial that you have read and understood the following:

_____ Reminder Calls/Emails: We understand that you are booking in advance and schedules get busy. We will provide you with a 2 business day courtesy call or email to you. Please let us know which number or e-mail we can reach you during office hours. If we leave you a message or send an e-mail it would be greatly appreciated if you could respond back that you have received our message.

_____ Office Cancellation Policy: Remember that once you have made an appointment, this time is reserved for you. Two working days notice is required if you are unable to keep your appointment or a charge may be applied to your account.

_____ Financial Policy: ALL FEES ARE DUE ON THE DAY OF TREATMENT. **DENTAL PLANS**: A dental plan is a contract between you and the insurance company, please be sure that your plan is in effect. We are considered a third party. As a patient you are responsible for payment for all treatment provided. Any amounts not covered by the insurance company are the patient's responsibility. Payment plans are available with arrangements made prior to services being rendered. *A SIN number is required. Please ask the front desk staff for details.

The information provided above is true to the best of my knowledge. I have read the office policy and agree to comply.

_____ _____
Signature of responsible party Date

UPDATED:
Date & initial

_____ _____ _____

_____ _____ _____