

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? <input type="checkbox"/> Internet <input type="checkbox"/> Newspaper <input type="checkbox"/> Patient / Other: _____			

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 \$200.00 charge may be

_____ 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