SIMCOE
FAMILY DENTISTRY

PATIENT REGISTRATION

Personal Information:

First Name: _____ Last Name:_____ Initial: _____

Address: _____ City/Prov: _____Postal Code: _____

Date of Birth: ____ /____ / _____ Age: ____ Email: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Preferred Contact Method: ☐Home Phone ☐Work Phone ☐Cell Phone ☐E-mail ☐ Text

By providing an email and/or cell phone number for text messages, I authorize Simcoe Family Dentistry to correspond with me in that manner. I understand that email and text message communications are not secure forms of communication and that confidentiality of any email or text message cannot be ensured. I understand that this authority is to remain in effect until Simcoe Family Dentistry has received written notification from me of its change or termination.

Emergency Contact: _____ Relationship: _____ Phone#: _____

Past Dental History:

Last time at a dentist and for what reason? _____

How many times a day do you brush? _____

How many times a day do you floss? _____

Do you have any dental concerns and if so, what are they?

_____

_____

_____

How did you hear about us?

☐Internet Search ☐Google Ad ☐Facebook ☐Patient Name: _____

☐Referred from another office: _____ ☐Other: _____

T: 705-792-0079 ● F: 705-792-0051
info@simcoefamilydentistry.com
11 Ferris Ln, Suite 301, Barrie, ON L4M 5N6

SIMCOE
FAMILY DENTISTRY

Financial/Insurance Information:

At Simcoe Family Dentistry, payment is due on the day treatment is provided. If you have dental insurance, we will gladly submit the claim electronically on your behalf to avoid re-imbursement delays. We accept Visa, MasterCard, Debit and Cash. Our fees are generally based on the ODA Fee Guide for the current year. If you have any questions regarding our fees, please inquire. Your appointment is time set-aside specifically for you with either our dentist or hygienist.

We require 48 hours notice to cancel or reschedule an appointment. If you need to change or cancel an appointment, please call during normal business hours. If an appointment is cancelled with less notice or you do not show for your appointment, we reserve the right to charge a cancellation fee. _____
Initial

Who is responsible for your account? ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Name of Insured:	Name of Insured:
Date of Birth:	Date of Birth:
Insurance Co.:	Insurance Co.:
Policy#: ID#:	Policy#: ID#:
Employer:	Employer:

I, the undersigned, state that I have completed all information forms accurately, without knowingly omitting any information. On the basis of confidentiality, I hereby consent to the release and transfer of any patient information and dental records within my file for dental insurance purposes or interpractitioner communication. I agree that **Simcoe Family Dentistry** have obtained informed consent from me with respect to the collection, use, and disclosure of my personal health information. If asked, I will be provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection Act, 2004. I also authorize release, to my benefits plan administrator and CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described Lifestyle Dentistry.

Signature: _____ Date: _____

T: 705-792-0079 ● F: 705-792-0051
info@simcoefamilydentistry.com
11 Ferris Ln, Suite 301, Barrie, ON L4M 5N6