Patient Information Form

Name _____

Birthdate _____ Email _____

Home Tel _____ Cell _____

Address _____

City _____ Postal Code _____

Driver's License (required for prescriptions) _____

Whom may we thank for referring you to our office?

☐ patient _____ ☐ Opencare

☐ Specialist/Dr _____ ☐ Facebook

☐ Instagram ☐ Sign ☐ Mailer

☐ Google ☐ Other _____

In case of emergency, whom should we contact?

Name _____ Home _____

Cell _____ Work _____

Physician's Name _____ Phone _____

Specialist's Name _____ Phone _____

Complete if you have dental insurance that you wish for us to send your dental claims to.

I authorize release, to my benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist.

This authorization shall continue in effect until the undersigned revokes the same

_____ _____

Signature of patient, parent or guardian Date