Welcome To Our Office

Patient Registration			*** Medical Alert*_____**
Last Name:	First Name:	Birthdate:	Gender: Female ( ) Male ( )
Personal Health Number:			
Address:			
City:	Province:	Postal Code:	
Home #:	Work #:	Cell #:	Other #:
Email:			
Employer:			

Primary Insurance Plan	**Secondary Insurance Plan**
Name of Insured: DOB:	Name of Insured: DOB:
Pt . Relationship: self / spouse/ child DOB: Dep:	Pt . Relationship: self / spouse/ child DOB: Dep:
Insurance Company:	Insurance Company:
Plan / Group #:	Plan / Group #:
Cert / ID #:	Cert / ID #:
Basic %: Prev.%: Major %: Ortho %:	Basic %: Prev.%: Major %: Ortho %:
Limits: B P M O	Limits: B P M O
Annual Financial Max $: sc/rp: units/yr	Annual Financial Max $: sc/rp: units/yr
Deductible: individual $ family $	Deductible: individual $ family $
Recall Frequency: 6 month 9 month 12 month	Recall Frequency: 6 month 9 month 12 month

Consent

1. This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I will assume responsibility for fees associated with those procedures.

2. I understand that responsibility for payment of dental services, including insurance or otherwise, is due and payable at the time services is rendered and despite any dental insurance, I am ultimately responsible for any fees withheld by the insurance company.

3. Your dental Insurance Policy is a contract between yourself, your employer and the insurance company. We are a third party to your plan and are only privileged to the details of your plan, which you provide us with. If you are unsure of the details, please ask your employer for a booklet outlining the details of your coverage. With your booklet, our staff are better able to help you understand your policy and to record the specific details to your file.

4. Your plan may contain financial, frequency and procedure limitations, which may or may not be in keeping with your dental health needs. We do not recommend allowing your insurance policy to dictate your dental treatment. Treatment should be based on individual needs in discussion with your dental professional. Knowing both your treatment needs and your plan limitations better enables you to make informed choices.

5. Please be aware of changes to your policy and make us aware of them as soon as they become effective.

I hereby assigned my benefits payable from all claims to the named Dentist "Dr. Stan Heinrichs" and authorized payments directly to him. I authorize release, to my insuring company plan administrator the information contained in claims submitted electronically.

I understand that I am financially responsible for the entire cost of Dental Treatment at Eagle Ridge Dental Centre. I have read and understand the above policy. I agree to pay any and all amounts unpaid or uncollectable by my Dental Insurance Plan.

Date: _____ Signature: Patient ( ) Parent ( ) Guardian ( )
(please mark 'x' which one applies)

Please help us maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, this time is reserved for you. 24 hours must be given if cancellation is necessary to avoid a charge.