Patient Registration

NORTH SHORE
PEDIATRIC DENTISTRY

Child's Contact Information *(please print only)*

Child's Name: ....
Last First Initial

Preferred Name: ....

☐ Male ☐ Female Birth Date...(MM/DD/YY) ....

Child lives with: ....

Child's Home Address: ....

....
City Province Postal Code

Child's Home Phone: ....

Child's Care Card No.: ....

Ministry Sponsored Plan: ....

Guardian's Contact Information *(please print only)*

☐ Father ☐ Mother ☐ Other: ....

Name: ....
Last First Initial

Birth Date: ...(MM/DD/YY) ....

Cell Phone: ....

Work Phone: ....

Email: ....

Insurance Information

Name of Insurance Company: ....

Member ID/ Cert. No.: ....

Group Plan / Policy No.: ....

Child's Dependent No.: ....

☐ Father ☐ Mother ☐ Other: ....

Name: ....
Last First Initial

Birth Date: ...(MM/DD/YY) ....

Cell Phone: ....

Work Phone: ....

Email: ....

Insurance Information

Name of Insurance Company: ....

Member ID/ Cert. No.: ....

Group Plan / Policy No.: ....

Child's Dependent No.: ....

Emergency Contact

Name: .... Phone: ....

How did you hear about our office?

☐ Dentist Referral ☐ Physician Referral ☐ Health Dept. ☐ Friend Name: ....

☐ Flyer/Mailing ☐ Internet ☐ Newspaper ☐ Other: ....

Personal Information Protection Act Consent Box

I consent that any information given to North Shore Pediatric Dentistry is to:

communicate with other health professionals, such as dentists, doctors, etc. on you and your child's behalf.

communicate with insurance provider on your behalf to facilitate your child's treatment.

communicate related servies and activities provided by NorthShore Pediatric Dentistry such as a newsletter or appointment reminder card

SIGNATURE: .... DATE: ....

I acknowledge that I am financially responsible for all charges. I am expected to pay for the services provided to my child on the day the services are rendered. If I am unble to commit to my scheduled appointment and fail to give a 24 hour cancelllation notice ahead of time, I understand I may be charged for the appointment. I authorize release, to my insuring company plan administration, the information contained in claims submitted electronically or manually.

SIGNATURE: .... DATE: ....