McFarlane
Family Dental

Date: _____

The information that is requested on this Questionnaire, Dental History and Medical History is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly.

REGISTRATION INFORMATION - This information will enable us to maintain communication with you.

The patient is an: Adult ☐ Child ☐ Adult under guardianship ☐ Name of Guardian: _____

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

Name: _____ (last) _____ (first) _____ (initial)

Prefers to be called: _____ Occupation: _____

Address: _____ (street) _____ (apt.#) _____ (city) _____ (province) _____ (postal code)

Home Phone: ( ) _____ Driver's Lic. No. _____

Bus. Phone: ( ) _____ Ext. _____ Employer: _____ May we call you at work? ☐

Cell Phone: ( ) _____ E-mail address: _____

Preferred method of contact: Phone ☐ Cell ☐ Text ☐ E-mail ☐

Name of Spouse: _____

Date of Birth: D____M____Y____ Age: _____ Gender: _____ Martial Status: _____

Whom may we thank for referring you? _____

Are there other family members patients at our office? Yes ☐ Names: _____

MEDICAL PRIORITY - This information will enable us to make any essential contacts.

Family Physician: _____ Phone: ( ) _____

Medical Specialist: _____ Phone: ( ) _____
(if presently under care)

Name of previous dentist: _____ Phone: ( ) _____

In case of emergency, please contact: _____ Phone: ( ) _____

Reason for today's visit? Examination ☐ Emergency ☐ Other ☐ _____

FINANCIAL INFORMATION - This information is necessary to process invoices and apply payments.

Person responsible for account: Self ☐ Spouse ☐ Other ☐ **Please complete all information if different than above.**

Name: _____ (last) _____ (first) _____ (initial) Phone: ( ) _____

Address: _____ (street) _____ (apt.#) _____ (city) _____ (province) _____ (postal code)

Employed by: _____ Phone: ( ) _____

Driver's Lic. No. (if required by office) _____ Health Card # _____

METHOD OF PAYMENT (if required by office) **CASH** ☐ **CHEQUE** ☐ **CREDIT CARD** ☐ **OTHER** ☐

PRIMARY DENTAL INSURANCE (If information required by office)				**SECONDARY DENTAL INSURANCE**			
Subscriber's name:		D.O.B.		Subscriber's name:		D.O.B.	
Emp./Grp/ policy holder:		Ins. yr. end		Emp./Grp/ policy holder:		Ins. yr. end	
Ins. Co.		Tel.		Ins. Co.		Tel.	
Grp./Ind. policy No.	Cert. No.			Grp./Ind. policy No.	Cert. No.		
I.D./S.I.N.	Max. Coverage			I.D./S.I.N.	Max. Coverage		
% coverage Basic	Maj. Rest.	Ortho.	Other	% coverage Basic	Maj. Rest.	Ortho.	Other