

Medical Alert:  
Note:  
A/c #  
For office use only

**WELCOME TO ROSSLAND /GARDEN DENTAL!**

***Please complete this form, if you have any questions please ask for help! PLEASE PRINT***

Today's Date: \_\_\_\_\_ How did you find out about this office? \_\_\_\_\_  
Day /Month/Year

Mr./Ms./Mrs./Dr. \_\_\_\_\_  
Patients: First Name Middle/Initial Last Name  
Date of Birth: \_\_\_\_\_ Health Card # \_\_\_\_\_  
Day /Month/Year  
Address: \_\_\_\_\_ Unit# \_\_\_\_\_ City: \_\_\_\_\_ Postal code: \_\_\_\_\_  
Home Phone# \_\_\_\_\_ Bus. # \_\_\_\_\_ Mobile# \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Emergency Contact: Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Bus. # \_\_\_\_\_ Mobile# \_\_\_\_\_

**Primary Person Responsible for this account:** *(Please fill in applicable information)*

Mr./Ms./Mrs./Dr. \_\_\_\_\_  
First Name Middle/Initial Last Name  
Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_ # \_\_\_\_\_  
Day/Month/Year Street Unit  
City: \_\_\_\_\_ Postal code: \_\_\_\_\_ Home # \_\_\_\_\_ Bus. # \_\_\_\_\_  
Mobile# \_\_\_\_\_ E-mail address: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
**Insurance Co:** \_\_\_\_\_ **Policy#** \_\_\_\_\_ **Cert.#** \_\_\_\_\_ **Div.** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Secondary Person Responsible for this account:** *(Please fill in applicable information)* Mr./Ms./Mrs./

Dr. \_\_\_\_\_  
First Name Middle/Initial Last Name  
Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_ # \_\_\_\_\_  
Day/Month/Year Street Unit  
City: \_\_\_\_\_ Postal code: \_\_\_\_\_ Home # \_\_\_\_\_ Bus. # \_\_\_\_\_  
Mobile# \_\_\_\_\_ E-mail address: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
**Insurance Co:** \_\_\_\_\_ **Policy#** \_\_\_\_\_ **Cert.#** \_\_\_\_\_ **Div.** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Address:** \_\_\_\_\_

*We are pleased that you have selected our Dental Office. It is our wish that your dental health is the best that it can be and we will try our best to make it a reality. We request that payment for services are made at each appointment. If you have dental insurance we will be glad to submit your claims for you. **Insurance is your responsibility.** Some treatments may require a partial or full prepayment. We accept cash, most credit and debit cards. If special arrangements are required please make sure you speak to us before commencement of treatment, otherwise payment is expected in full as treatment is done. Please select your method of payment:*

Cash Visa / Master Card: # \_\_\_\_\_ Expiry date: \_\_\_\_\_

Debit Card #: \_\_\_\_\_ Bank: \_\_\_\_\_

Signature: \_\_\_\_\_

*Please turn over, complete and sign the medical questionnaire and consent form. Thank you!*