

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 and wish to assign your benefits to us, so that your insurance can pay us directly please sign below: (Please note that all fees not covered by your insurance are your responsibility)*

*I authorize release of information contained in claims submitted electronically to my dental benefits plan administrator and the CDA. I also authorize the communication of information related to the coverage of services described to Dr. Hattay and hereby assign my benefits, payable from claims submitted electronically, and authorize payment directly to Dr. Hattay. This authorization shall continue in effect until the undersigned revokes the same.*

Signature of patient, parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Otherwise, payment is expected in full as treatment is done. Please select your method of payment:

Cash     Debit Card #: \_\_\_\_\_ Bank: \_\_\_\_\_  
 Visa / Master Card/Other \_\_\_\_\_ : # \_\_\_\_\_ Expiry date: \_\_\_\_/\_\_\_\_

Signature of patient, parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

*Please turn the page over and complete the patient information and sign at the bottom. Thank you!*