

Personal and Insurance Information

Please visit our website: www.evergreendentistry.ca or www.CreatingExceptionalSmiles.com

Name: _____ M__ F__ Birthdate (M/D/Y) _____

Address: _____ / _____ / _____ / _____ / _____
Street Apt # City Province Postal code

Healthcard Number _____

Phone Numbers: Home: (____) _____ Cell: (____) _____

Business: (____) _____ Emergency contact: (____) _____

Email address: _____

I agree to receive email messages from Evergreen Dental which may include appointment confirmations, newsletters, upcoming events and important notifications. You may withdraw your consent at any time.

How did you hear of our office:

Advertising Website Location Other: _____

Whom may we thank for the referral? _____

I will most often pay my account by:

Cash Debit Visa/Mastercard

Are you a full-time student? Yes No

Name of school: _____

Insurance information: (Please bring coverage information to appointment)

1- Policy Holder: _____ Date of Birth: _____

Name of Insurance Company: _____

Employed by: _____

Group/Policy: _____ Certificate: _____

2-Policy Holder: _____ Date of Birth: _____

Name of Insurance Company: _____

Employed by: _____

Group/Policy: _____ Certificate: _____

Please understand that we require 2 business days notice for changes to appointments to avoid a missed appointment fee. Changes in appointment times with due notice must be made during business hours (8:00-5:00). **Payment for services is required at the time of service. Direct billing is a courtesy our clinic provides for your convenience.** We are not responsible for the particulars of your policy and have no control regarding changes that are made to those policies. We will accept direct payment from the primary policy only, and we will submit on your behalf for the second insurance to pay you the patient directly as you will be responsible for payment not covered by your primary insurance to us.

I understand that I am responsible for reporting any changes or cancellation of my insurance plan.

I understand that all fees may not be covered by or may exceed my plan benefits.

Signature: _____ Date: _____