DENTAL

Dr. Paul Bonazza
Dr. David Fiore
Dr. Kristyne Seymour

530 Portland Street
Dartmouth, Nova Scotia
B2Y 4V6

Tel (902) 442-0200
Fax (902) 406-0200

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

Insurance information: (Please bring coverage information to appointment)

Policy Holder 1: ___________________________ Date of Birth:________________

Name of Insurance Company: ______________________________________

Employed by: ____

Group/Policy: _______________________ Certificate: ___________________

Policy Holder 2: ___________________________ 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:__________________

Are you comfortable with dental treatment? ____________________________

Do you have specific goals/requests for dental treatment?

____

Email
info@evergreendentistry.ca