Granada Dental

Date: _____

Name: _____ Date of Birth: _____ Gender: M F Other: ___
Last First Name Initial Month Day Year

Address: _____
Street City Postal Code

Home Phone: _____ Business Phone: _____ Cell: _____

E-Mail: _____ **What is the most convenient way to contact you?** _____

Occupation: _____

SIN: _____ Alberta Healthcare Number: _____

Marital Status: _____ Name of Spouse: _____

Emergency Contact: _____ Phone: _____

(If Child) Name of Parent or Guardian: _____

Person Responsible for Account Balances: _____
Name Relationship Phone Number

Family Medical Doctor: _____
Name Phone Number

Pharmacy: _____
Name Phone Number

Previous Dentist: _____ Date of Last Dental Exam: _____

How did you hear about our office? _____

Do you have dental insurance: Yes No
If Yes please provide the following:

Primary Insurance Co: _____ Policy: _____ ID: _____

Policy Holder: _____ Date of Birth: _____ Relationship to Client: _____

Employer: _____

If you have more than one insurance policy complete this section:

Secondary Insurance Co: _____ Policy: _____ ID: _____

Policy Holder: _____ Date of Birth: _____ Relationship to Client: _____

Employer: _____