auroradentalcentre

Patient Registration Form

visit our video website at auroradentalcentre.com

Personal Information

NAME: Mr. / Miss / Mrs. / Ms. / Dr.		DATE OF BIRTH:
ADDRESS:		
HOME PHONE:	CELL PHONE:	
EMAIL ADDRESS:		
EMERGENCY CONTACT:	RELATIONSHIP:	PHONE #:
ARE FAMILY MEMBERS PATIENTS AT OUR OFFICE? ☐ yes ☐ no Names:		
Whom may we thank for referring you?		

Financial / Insurance Information

At Aurora Dental Centre payment is due when services are rendered. If you have dental insurance, we will submit the claim on your behalf. We accept Visa, MasterCard, Debit, Cheques and Cash as method of payment. Our fees are based on the ODA Fee Guide for the current year. If you have any questions regarding our fees, please inquire.

Person responsible for your account:
☐ Self ☐ Parent / Guardian ☐ Spouse ☐ Other: _____

Primary Dental Insurance		**Secondary Dental Insurance**	
Subscriber:		Subscriber:	
Date of Birth:		Date of Birth:	
Insurance Co.:		Insurance Co.:	
Policy #:	ID#:	Policy #:	ID#:
Employer:		Employer:	

I, understand, state that I have completed all information forms accurately, without knowingly omitting any information. On the basis of confidentiality, I hereby consent to the release and transfer of any patient information and dental records within my file for dental insurance purposes including submitting dental claims or pre-determinations or for any inter-practitioner communication. I agree that Aurora Dental Centre has obtained informed consent from me with respect to the collection, use, and disclosure of my personal health information. If asked, I will be provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection Act, 2004.

Signature: _____ Date: _____

Patient or Parent / Guardian