Confidential Personal Information/Dental Information

Last Name: ______________________ Middle Initial: ______ First Name: ____________________

Birthdate mm/dd/yyy: ____________________ Gender: male female other

Address: ____

City: _______________________ Province: ________ Postal Code: _____________________

Primary Email: ________________________________

Cell #: ____________________ Work #: ____________________ Home #: ____________________

Emergency Contact:

Name: _________________________________ Relation: ______________________

Contact #: _______________________________

Dental Information:

Previous Dentist/Office: ________________________________ Last dental visit: ______________

Any dental questions or concerns? ____

Are you currently in any dental discomfort or pain? Yes No

Explain: ____

Consent for Treatment/Accountability Confirmation:

To the best of my knowledge all preceding information provided is true, complete and accurate. Permission is granted for Uxbridge Dental Care to contact me to discuss matters related to my personal information. It is understood this information is held in the strictest confidence. It is my responsibility to inform/update Uxbridge Dental Care of any changes to my medical status. I understand all the policies of Uxbridge Dental Care. I understand and agree to pay all fees associated with my dental treatment with or without insurance coverage.I understand it is my responsibility to be aware of fees prior to any dental treatment I authorize to be rendered.

Signature of Client: ___________________________________ Date: ___________________________

Printed Name: ____________________________

We appreciate all referrals. Please let us know whom we may thank for your referral: