Daphne Kwan Dentistry Professional Corporation

5851 Leslie Street, Toronto, M2H 1J8

Last Name _____ First Name _____ Date of Birth: mm/dd/yy _____

Address _____

Home Phone _____ Business Phone _____ Cell Phone _____
(Please indicate which phone no. you would prefer to be contacted . Home/Business/Cell)

Occupation _____ Employer's Name _____

Employer's Address _____

In case of emergency, please contact _____ Phone _____ Relationship _____

How do you know about this office?_____

Whom may we thank for referring you to our office?_____

DENTAL INSURANCE INFORMATION

Name of Subscriber _____ Subscriber's Date of Birth(mm/dd/yy) _____

Name of Subscriber's company _____ Name of Insurance Company _____

Policy No. _____ Div. No. _____ Cert. No _____

Secondary Insurance (If applicable)

Name of Subscriber _____ Subscriber's Date of Birth (mm/dd/yy) _____

Name of Subscriber's company _____ Name of Insurance Company _____

Policy No. _____ Div. No. _____ Cert. No _____

I authorize release, to my dental benefit plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

Signature of patient/ guardian _____ Date _____

I certify that I have provided an accurate and complete personal and medical history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I consent to my physician, other dentists or dental specialists being contacted for consultation if needed. I ensure responsibility for payment of dental services, and am obligated to pay said office in accordance with its credit terms and policy.

Signature of patient/ guardian _____ Date _____