SCOTTSDALE SQUARE DENTAL CENTRE ssdc

PATIENT REGISTRATION AND HEALTH HISTORY

Patient Information

Name: Last | First | Init | (Mr. / Mrs. / Ms. / Miss / Mstr)

Address

CITY | Province | Postal Code

Phone: Home | Business | Birthdate (D/M/Y)

If patient is a child, please provide the following information:

Name of Legal Guardian

Relation | Business Phone No. | Occupation:

Skip this portion if you had previously completed this for another family member.

DENTAL INSURANCE INFORMATION (Let our receptionist help you with this section)

Policy 1 Company | S.I.N. | Dep#

Policy No. | Subscriber ID | Deductible

Coverage: A) Basic | B) Major | Comp Paid On Molars: Y/N

Limits: A) | B) | A& B) | Perio Limit:

Subscriber | Birthdate (D/M/Y)

Employer | Contact | Phone

Notes: | Send To: Y / N

Policy 2 Company | S.I.N. | Dep#

Policy No. | Subscriber ID | Deductible

Coverage: A) Basic | B) Major | Comp Paid On Molars: Y/N

Limits: A) | B) | A& B) | Perio Limit:

Subscriber | Birthdate (D/M/Y)

Employer | Contact | Phone | Send To: Y / N

CONSENT FOR RELEASE

I authorize release, to my Insuring company plan administrator, the information contained in claims submitted by Scottsdale Square Dental Centre on behalf of the patient indicated above.

x _____ _____

Signature/s of Patient or parent/guardian | *Date (D/M/Y)*

ASSIGNMENT OF BENEFITS

I hereby assign benefits payable from claims submitted by Scottsdale Square Dental Centre and/or Dr. Terry Mah and/or Scottdale Square Dental Centre and authorize payment directly to the office, doctor or associate.

x _____ *x* _____ _____

Signature of Subscriber for Policy 1 | *Signature of Subscriber for Policy 2* | *Date (D/M/Y)*

Medical Alert