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WELCOME TO OUR DENTAL OFFICE. Your cooperation in completing this form is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain within this office. Our reception team members are available to assist you with the completion of this form. **Please Print**

REGISTRATION INFORMATION

Name _____

Address _____

City _____ Postal Code _____

Date of Birth (d/m/y) _____ Sex M_____ F_____

Home # _____ Work # _____

Cell # _____ Email _____

Employer/Occupation: _____

Emergency Contact/Spouse/Parents _____ Phone # _____

Referrals are important to us. Who may we thank for referring you to our office? _____

PREFERRED MEANS OF CONTACT

Please select either phone, text or email option. We will contact you for all future scheduled appointments by this method only. Note that an Autoreply to the email/text option will be required to confirm the appointment. Any missed or cancelled appointments within 24 hours will incur a charge. (as per our Office Policies attached)

☐ Call to Home # ☐ Call to Work #

☐ Text to Cell # ☐ Email

Signed & Dated: _____