Smile Centre
DENTAL

New Patient Information

First Name: ______________________________ Last Name: ______________________________

Address: ____

City: ______________________________ Province: __________ Postal Code: ______________

Home Phone: ____________ Cell Phone: ________________

E-Mail: ____

Gender: ____________________ Birth Date (DD/ MM/ YY) : ______________________________

Insurance Information:

Employer: ____________________ Insurance Company: ______________________________

Policy / Group Number: _______________ Certificate / Unique ID Number:___________________

**If you have a secondary insurance , please fill another New Patient Information for that Policy Holder.*

We will be happy to complete your insurance forms and submit them electronically when possible. You are required to pay the remaining balance not paid by the insurance policy. Our team will gladly assist you in understanding your coverage but ultimately the financial responsibility for service rests with the patient regardless of any insurance coverage. Your insurance policy is a contract between you, your employer and the insurance company. We cannot guarantee coverage of your claim. If you require a predetermination, please notify us before your appointment.