West Village Dental Centre
DEPENDANT PATIENT INFORMATION

PATIENT INFORMATION					**DATE**
Last Name	First Name		Middle Initial		Preferred Name
Street Address		City / Town		Province	Postal Code
Home Phone	Mobile Phone	Work Phone	Ext.	E-mail	
Birth date *(dd/mm/yyyy)*	Age	Sex	Best days and times for appointments *(circle all that apply)* **MON TUE WED THU Early AM AM Lunchtime PM Late PM**		
School / Employer		Grade / Position			
Emergency Contact	Relation	Contact Number		Contact E-mail	

Prefix	Parent / Guardian Last Name	First Name	Middle Initial	Preferred Name
Street Address *(if different from above)*		City / Town	Province	Postal Code
Home Phone	Mobile Phone	Work Phone Ext.	E-mail	
Birth date *(dd/mm/yyyy)*	Employer	Occupation		
How did you become aware of West Village Dental Centre? *(circle any that apply)* **Friend/Family Website Building/Sign Google/Internet Other**		Who may we thank for the referral?		

OFFICE POLICIES & PROTOCOLS *(for Parent / Guardian)*	**Initials**
COMMUNICATION - Information gathered is considered confidential and necessary for West Village Dental Centre to provide you with the best possible dental care. For appointment reminders, you would prefer: **HOME □ WORK □ CELL □ E-MAIL □ TEXT □**	_____
CONSENT TO DENTAL PROCEDURES - I consent to the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local or general anesthesia as indicated.	_____
CANCELLATIONS / NO SHOWS - Appointments are time set aside specifically for you, which our dental care team prepares for in advance. Appointments are considered confirmed once scheduled. However, West Village Dental Centre will make every effort to contact the patient, in advance, as a reminder. If an appointment is unable to be kept, the courtesy of two (2) full business days' notice is expected. Patients who fail to show up for scheduled appointments, without notice of extenuating circumstances, risk being asked to seek dental services elsewhere. *We reserve the right to charge a cancellation / no show fee.*	_____
ACCOUNTS / PAYMENTS - Please indicate with your initials your understanding of West Village Dental Centre's payment policy: "I will pay all amounts not covered by insurance at the conclusion of each appointment by one of the approved payment methods – VISA, MASTERCARD, AMERICAN EXPRESS, INTERAC / DEBIT OR CASH. West Village Dental Centre will submit, on my behalf, any claim forms required by my primary and secondary benefit plan providers to facilitate reimbursement for the amounts detailed in my plan. I am aware that while West Village Dental Centre will assist, it is my responsibility to understand the details of various conditions and limits that may appointment to my plan(s). I am aware that West Village Dental Centre is NOT responsible for any portion of the fees not covered or paid for by the benefit plan carrier. The role of my dental health team is limited to the provision of dental care and this is separate from any aspect of my benefit plan. Thus, I understand that I am financially responsible for all dental health care services which I have received."	_____

EDI **(Electronic Data Interchange)**	**I authorize release of the information contained in dental claims submitted to my benefit company, plan administrator, and plan member.**	**Signature (Parent / Guardian)**