TERRITORIAL DENTAL CLINIC

# WELCOME TO OUR OFFICE

Name: _____
Last First Initial

Sex: ☐ M ☐ F Date of Birth: _____ *Email Address: _____
(DD/MM/YY)

Telephone: _____ | _____ | _____
*Cell Home Work

Mailing Address: _____
Street City Postal Code

Family Physician: _____ Health Card Number: _____
Exp. Date

Occupation: _____ Employer: _____

Spouse Employed By: _____

If a Child (Parent/Guardian's Name): _____ Ph. (If Different): _____

In Case of Emergency Notify: _____ Relationship: _____ Ph: _____

How did you hear about our office? (Check all that apply)

☐ Billboard ☐ Google ☐ Radio ☐ Phonebook

☐ Denture Clinic ☐ Facebook ☐ Referral ☐ Friend/Existing Patient_____

☐ Other_____

Dental Insurance: ☐ Yes Please provide receptionist with a copy of your insurance policy card(s)
☐ No

How will you be paying for today's treatment? (Please Circle) ☐ **Visa** ☐ **M/C** ☐ **Debit** ☐ **Cash**

10 Digit Treaty Number (if applicable): _____

Office Policy requires **confirmation** of your appointment **by noon**, the **day before** your appointment. If we **cannot confirm** your appointment, it **may be rescheduled**.

A **reminder email** is sent **2 weeks prior** to your appointment.

A **confirmation text** message is sent **2 days prior** to your appointment. The **link** on the text message can be **clicked to confirm** your appointment.

If we don't hear from you, we will **contact** you **via phone call** the **day before** for confirmation.

If you **cannot make** your **appointment**, we kindly request a **minimum of 48 hours'** notice for rescheduling your appointment.

Missing or cancelling multiple appointments without a minimum of 48 hours' notice will compromise your standing in the clinic.