AIRDRIE DENTAL STUDIO

# Patient Information Form

Date: _____

Name: _____ _____ _____

Last Given Initial

Date of Birth: _____ Age: _____ Male: ____ Female: ____

(DAY/MO/YEAR)

Home address: _____

Postal code: _____ Email: _____

Phone: _____ Business: _____ Cell: _____

Airdrie Dental sends email and text communications which may include appointment confirmations, newsletters, upcoming events and important notifications. Would you like to receive future electronic communication from us?

Yes: _____

No: _____

*You can withdraw your consent at any time.*

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How did you hear about our office: _____

Health Care #: _____

Occupation: _____

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**Dental Insurance**

Primary: Name of insurance company: _____

Group/Policy #: _____ ID/Certificate #: _____

Policy Holder: _____ DOB: _____

Employer: _____

Secondary: Name of insurance company: _____

Group/Policy #: _____ ID/Certificate #: _____

Policy Holder: _____ DOB: _____

Employer: _____

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**PERMIT FOR OPERATIONS**

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of the local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's Signature: _____ Date: _____

Parents Signature (Patient is under 18): _____ Date: _____