CROWFOOT
DENTAL STUDIO

Patient Information

Patient's Name: ______________________________________ Date of Birth: ____________(DD/MM/YYYY)

Preferred Name: ______________________________________ Gender: ____________________

Home Phone #: ________________ Cell Phone #: __________________ Work Phone #: _________________

Patient's Address: ____ Postal Code _____________

Email Address: ____

Occupation: ________________________________ Family Physician: ________________________________

Name and Phone number of Emergency Contact: ____

Other family members that are patients here: ____

How did you hear about us: ☐ Signage/Location ☐ Google ☐ Internet/Website ☐ Social Media ☐ Mailer
☐ Family/Friends: ____ ___

Insurance Information

Do you have insurance coverage? ☐ Yes ☐ No

Primary Insurance	**Secondary Insurance**
Name of Insurance Plan:	Name of Insurance Plan:
Name of Subscriber:	Name of Subscriber:
Date of Birth:	Date of Birth:
Group/Policy No:	Group/Policy No:
Certificate/ID No:	Certificate/ID No:

Request for Confidential Communication

As my dental care provider, you may do the following with my permission:

	Yes	No
Contact me at home	☐	☐
Contact me via cell phone	☐	☐
Contact me at work	☐	☐
Contact me via email	☐	☐
Leave messages on my home voicemail	☐	☐
Leave messages on my cell phone voicemail	☐	☐
Leave message on my work voicemail	☐	☐