

# Goma Dental – Patient Information

PATIENT'S NAME: \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

MALE ✍ FEMALE ✍

DATE OF BIRTH \_\_\_\_\_

PARENT'S NAME (if child): \_\_\_\_\_

HOW DO YOU WISH TO BE ADDRESSED: \_\_\_\_\_

SINGLE ✍ MARRIED ✍ SEPARATED ✍  
DIVORCED ✍ WIDOWED ✍ MINOR ✍

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ POSTAL \_\_\_\_\_

PHONE # HOME - \_\_\_\_\_ CELL - \_\_\_\_\_

EMAIL ADDRESS - \_\_\_\_\_

(please include as important notices and monthly draws are sent via email)

PLACE OF WORK - \_\_\_\_\_

WORK ADDRESS - \_\_\_\_\_

## DENTAL INSURANCE – FIRST COVERAGE

EMPLOYEE NAME \_\_\_\_\_ SAME ✍

EMPLOYEE DATE OF BIRTH \_\_\_\_\_ SAME ✍

EMPLOYER \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_ POSTAL \_\_\_\_\_

OCCUPATION \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_

POLICY/GROUP# \_\_\_\_\_

CERTIFICATE/ID/CONTRACT# \_\_\_\_\_

REASON FOR THIS VISIT \_\_\_\_\_

DATE OF LAST VISIT \_\_\_\_\_

OTHER IMMEDIATE FAMILY MEMBERS WHO ARE PATIENTS HERE \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

METHOD OF PAYMENT:

DEBIT ✍ CREDIT ✍ CASH ✍ CHEQUE ✍

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT

LIVING WITH YOU: \_\_\_\_\_ PHONE \_\_\_\_\_

## RELEASE

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dental specialist or health care provider, only if deemed necessary for the beneficial health care of the patient.

## CONSENT

- I have been examined and I am aware of the sequence of the treatment required. I choose to undergo this line of treatment required as appearing on cash record from all alternatives given to me. I am aware of limitations and probable results of the treatment.
- I further consent to other additional treatment not described to me today, as may be needed due to unusual development or conditions discovered during the treatment course.
- If use of anaesthesia is indicated, I consent to its use which may be in nature of surface/infiltration/TIVA/General Anaesthesia as my dentist may deem advisable. I have disclose the necessary medical and dental history. I have been explained the mode of payment and agree to the same.

I have read the above conditions of release and consent and agree to their content AND attest to the accuracy of the information provided on this page:

PATIENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PLEASE TURN OVER TO COMPLETE MEDICAL HISTORY