Date:_____

Dental Care
DR. LINDSAY TUCKWOOD

Med Alert (for office use only)

The information requested on this Questionnaire and Medical History is essential to providing you with the highest standard of dental care.
The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly.

ADULT or GUARDIAN REGISTRATION *PLEASE PRINT*

Name:_____
(First) (Last) (Middle Init)

Address:_____
(Street)

_____
(City) (Prov/State) (Postal code)

Date of Birth:____/____/____ Driver's Lic or OHIP #: _____
M D Y

Home Phone: _____ Cell Phone: _____

Email Address: _____ ☐Consent to receive email

Emergency Contact: _____ Phone #: _____

CHILD or UNDER GUARDIANSHIP REGISTRATION

Name:_____
(First) (Last) (Middle Init)

Address:_____
*if different from guardian (Street)

_____
(City) (Prov/State) (Postal code)

Date of Birth:_____ Age: ____ Gender: _____
M D Y

Home Phone: _____ Cell Phone: _____

Family Physician: _____ Phone: _____

Occupation:_____

Employer:_____ Phone: _____

Dental Insurance Provider: _____ Subscriber #: _____ Policy #:_____

Secondary Insurance: _____ Subscriber #: _____ Policy #:_____

Person Responsible for Account: Self ☐ Spouse ☐ Other ☐
(below information to be completed if person responsible for account other than self)

Name:_____D.O.B:_____
(First) (Last)

Address:_____
*if different from guardian (Street)

_____
(City) (Prov/State) (Postal code)

Family Physician: _____ Phone: _____

Whom may we thank for referring you? _____

Reason for today's visit: _____

_____