HootSmile
FAMILY DENTISTRY

# PATIENT INFORMATION

Welcome to our Practice!

Patient Name _____Date of Birth: _____ Sex: _____ Age: _____
Day/Month/Year

Home Address: _____ City: _____ Prov: _____ Postal Code: _____

Home Phone_____ Mobile Phone: _____ Work: _____

Email: _____

Emergency Contact Name: _____ Relationship: _____Phone: _____

How did you hear about our Practice: _____

## PRIMARY DENTAL INSURANCE

Company Name_____

Subscribers/Policy Holders Name: _____ DOB: _____
Day/Month/Year

Group # _____ ID or CERT _____

Basic % of Coverage_____Major % _____ Maximum Per Year: _____

What restrictions do you have on your dental plan_____

(ie. How often is polishing covered? Is fluoride covered? How many units of scaling are covered?)

## SECONDARY DENTAL INSURANCE

Company Name_____

Subscribers/Policy Holders Name: _____ DOB: _____
Day/Month/Year

Group # _____ ID or CERT _____

Basic % of Coverage_____Major % _____ Maximum Per Year: _____

What restrictions do you have on your dental plan_____

(ie. How often is polishing covered? Is fluoride covered? How many units of scaling are covered?)

Patient(Parent/Guardian Signature)_____Date:_____
Day/Month/Year