

Last Name _____ First Name _____ Date of Birth

Address _____ Apt. _____

City _____ Province _____ Postal Code _____

Home Phone - - Business - - Cell - -

Email Address _____ Sex _____ Marital Status _____

Occupation _____ Employer _____

Emergency Contact _____ Relationship _____ Phone - -

Whom may we thank for referring you to our office? _____

Financial Policy

2000 Yonge Dental requires payment in full for services rendered on the day of treatment. For your convenience we accept Debit, Visa and Mastercard.

For patients with dental insurance:

We also accept direct payment from your dental insurance company. In order to provide exceptional service and to deliver quality care to our patients, we can submit a predetermination or estimate to your insurance carrier prior to commencing any major treatment or as requested by you. However, all fees for major work will be collected in full at time of services. For major work (crowns/dentures/implants), we will be assisting you in completion of the insurance forms.

Please read carefully before selecting your preferred payment option.

Payment Option 1: Assignment of insurance benefits directly to 2000 Yonge Dental

I authorize my insurance carrier to pay 2000 Yonge Dental directly. I understand that my dental insurance is a contract between myself and my insurance carrier. It is, therefore, my responsibility to understand what my insurance coverage entails. I understand that I am responsible for any deductibles and/or differences in fees not covered by my insurance plan. I am providing my credit card information to be kept on file for this reason and to clear any balance on my account within 60 days.

Credit card type: Visa Mastercard

Credit card number

Name on card _____ Expiry date CVV

Signature _____

Payment Option 2: Payment by patient on day of service

I choose not to leave my credit card information on file. Therefore, I agree to pay for the services rendered on the day of treatment. 2000 Yonge Dental will aid in the submission of insurance claims wherever possible. The insurance company will reimburse me directly.

Appointment Policy

When you make an appointment with our office, we consider this a mutual commitment and reserve appropriate facilities and staff exclusively for you. If you find that you must change your appointment, we require a minimum of 2 business days' notice. If appointments are missed/broken without advance notification, a fee will be applied to your account.

General Consent to Treatment

I agree and consent to a dental examination at 2000 Yonge Dental. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. I also acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize 2000 Yonge Dental to release any information regarding my dental/medical history, diagnosis or treatment to other health professionals as necessary.

Communication

I authorize 2000 Yonge Dental to communicate with me via text, email and telephone.

I understand and will comply with the policies outlined above.

Signature of patient, parent or guardian _____ Date