APEX SURGICAL | Centre for Oral + Facial Surgery

Date:_____

Patient Information:

First Name: _____ Middle Initial:____ Last Name:_____

Date of Birth:_____ (dd/mm/yyyy)

Phone Numbers: (h) (___)_____ (c) (___)_____ (other) (___)_____

E-mail address:_____

Home address:_____ City/town:_____

Province:_____ Postal Code:_____

MSP/Care Card #_____ Exp:_____

Family Dr. Name: _____ Contact Number: (____)_____

Guardian Information (If patient under 18):

First Name: _____ Middle Initial:____ Last Name:_____

Date of Birth:_____ (dd/mm/yyyy) Relationship to Patient:_____

Phone Numbers: (h) (___)_____ (c) (___)_____ (other) (___)_____

E-mail address:_____

Home address:_____ City/town:_____

Province:_____ Postal Code:_____

Please note:

Due to the nature of services we provide at APEX Surgical, payment in full is required for all services rendered. We are happy to assist you with reimbursement from your insurance plan by providing you with a completed Dental Claim Form with all the specifications required by insurance companies to process your claim.

Please provide us with your dental insurance information:

Primary Carrier:_____ Name of Insured:_____

Policy Number:_____ ID#:_____ Employer:_____

Basic %:_____

Secondary Carrier:_____ Name of Insured:_____

Policy Number:_____ID#:_____ Employer:_____

Basic%:_____