Clinique dentaire du Portage

Dental Clinic du Portage

Ordre des dentistes du Québec

Personal Information Questionnaire

Date:_____

Please fill out the personal information section below.

Last Name:_____ First Name:_____

Sex: *M*❑ *F*❑ Date of Birth: *Day*:____*Month*:____ *Year*: _____ Guardian(-18):_____
Address:_____ Apt:____ City:_____ Province:_____ Postal Code:_____
Telephone: *Home*:(____)_____ *Work*:(____)_____(ext.)_____ *Other*:(____)_____
E-mail Address: _____
Health card no.:_____ Expiry date:_____ SIN (optional):_____
Referred by:_____ Motive for visit: _____

Employer:_____ Present Position:_____ How long held:_____
Telephone: (____)_____ E-mail Address: _____
Business Address: _____ City:_____ Province:_____ Postal Code:_____

Emergency Information

Name	Relationship	Telephone 1	Telephone 2
1.		(___)	(___)
2.		(___)	(___)
3.		(___)	(___)

Do you have insurance that may cover our professional services? *Y* ❑ *N* ❑
Name of insurance company:_____
Policy number: _____ Certificate number:_____

If you are not the person responsible for paying this account, fill out the section below with his or her information.

Last Name:_____First Name:_____
Sex: *M*❑ *F* ❑ Date of Birth: *Day*:_____*Month*:_____ *Year*: _____ Relationship to patient:_____
Address:_____Apt:____City:_____ Province:_____ Postal Code:_____
Telephone: *Home*:(____)_____ *Work*:(____)_____(ext.)_____ *Other*:(____)_____
E-mail Address: _____

Signature of party responsible for payment:_____ Date: _____

Patient signature:_____ Date: _____

Guardian signature (18 and under):_____ Date: _____