MONTREUX DENTAL CLINIC

Confidential Patient Information

Name: (First) ____________________ (Last)____________________ Middle Initial:___ Preferred Name:__________

Birthdate: (Day)____________(Month)__________(Year)________Age:________Gender: Female Male

Address:____________________________________City/Prov:________________Postal Code:__________

Email Address:________________________Employer:______________Occupation:________________

Home Ph:______________________Cell Ph:______________________Work Ph:________________

Best way to contact you (please circle): home / cell / work / e-mail

Emergency Contact Name / Relationship:______________________________Phone:______________

Other family members that are patients here:____

How did you hear about us? ❑Website ❑Walk-in ❑Other______________________________

For Insured Patients:

Insurance Information: **Primary Insurance Co.**________________________ Policy Holder: ____________________

Birthdate: ______________ Group no.________________________ ID no.__________________________

Secondary Insurance Co. ________________________ Policy Holder: ____________________________

Birthdate: ____________ Group no.__________________________ ID no.__________________________

SunLife members: Do you consent to allow Montreux Dental Clinic to access your information using SunLife Direct? YES NO

Would you like Montreux Dental Clinic to direct bill your insurance? YES NO

If circled YES - In order to provide the courtesy of direct billing your insurance, you must leave a credit card number on file for any uncovered or uncollectable insurance benefits.
If circled NO – you must pay all patient portions at the time of treatment, and send a claim form to your insurance manually.

I, (card holder's name)________________________ authorize Montreux Dental Clinic to charge my credit card for an outstanding dental balance after my dental insurance payment is received/acknowledged.

Visa MasterCard (Please print clearly)

Card #:__________________________________ Expiry: M_____ Y_____ 3 Digit Code on Back:_________

Signature of Card holder: ______________________________________

**Please note that we do not accept American Express, and apologize for any inconvenience!*

Appointment Cancellation Policy

Thank you for allowing us to be your dental care provider. We look forward to a long and healthy relationship in the care of your teeth and gums! For any appointments scheduled, we kindly request a minimum of ***48 hours notice*** to make changes to any dental appointment. **Failure to provide adequate notice will result in a $50 - $100 fee applied to your account (depending on the type of appointment).**

Consent for Treatment: I, the undersigned, clearly understand the policies of the dental office. I understand and agree to pay all fees associated with my dental treatment. I agree to make myself aware of these fees prior to any treatment I authorize to be done.

Patient/Guardian Signature ________________________ Name________________________ Date ____________

Dr. W. Elsaghir and Staff warmly welcome you!