# DR. ELON GRIFFITH DENTAL CARE

## PATIENT REGISTRATION FORM

Please take a moment to enter or update your information to help us serve you better. Please print to ensure clarity.

Today's Date _____

Patient Last Name _____ First Name _____ Middle Name _____

Preferred Name _____ Title (Dr., Mr.,Ms….) _____ Male or Female _____

Birth Date: Month_____Day_____Year_____

Contact Information: Mobile Number _____ Home Number _____ Work _____

Email _____ Preferred contact method (Email? Text? Call?) _____

Address: Street _____ Apartment _____

City _____ Province _____ Postal Code _____

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

### DENTAL INSURANCE

Do you have Dental Insurance Coverage? ☐ Yes ☐ No

Are you covered by more than one Dental Insurance Plan? ☐ Yes ☐ No

Are you covered by a student insurance plan? ☐ Yes ☐ No

If yes, which university or college Dental insurance Plan?_____

Are you covered by a government benefit plan? ☐ Yes ☐ No

If yes, which plan?_____

### PRIMARY DENTAL INSURANCE

Please ensure that the information included below corresponds exactly to the information on your insurance card.

Last Name of Insured _____ First Name _____ Middle Name _____

Insured's Date of Birth: Month_____Day_____Year_____

ID (or Member or Certificate) Number: _____

Group (or Plan) Number: _____

Division Number (if any):_____

Insured's Address: Street_____Apartment_____

City_____Province_____Postal Code_____

***( Please complete side 2 )***

*Side 2* _____

**SECONDARY INSURANCE**

Complete when patient has coverage by more than one insurance policy. Please ensure that the information included corresponds exactly to the information on the insurance card.

_____ / _____ / _____

Last Name of Insured First Name Middle Name

Insured's Date of Birth: Month_____Day_____Year_____

ID (or Member or Certificate) Number: _____

Group (or Plan) Number: _____

Division Number (if any):_____

Insured's Address: Street_____Apartment_____

City_____Province_____Postal Code_____

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**OFFICE POLICIES AND PROCEDURES**

**PRIVACY:** All personal information provided to us by a patient is treated as confidential information. No one is given unauthorized access to your personal information.

Patient information is collected to deliver safe and efficient patient care, to assess your health needs, to advise you of treatment options, to offer and provide treatment, care and services in relation to the oral and maxillofacial complex and dental care generally, and to allow us to efficiently provide follow up treatment. Our office also uses information to schedule and confirm appointments and distribute health care information.

Patient information may be provided to other health care providers, including dentists and specialists who are either referred from or referred to dentists and to comply with legal and regulatory requirements of the Royal College of Dental Surgeons and the Regulated Health Professionals Act. Patient information may also be provided to your insurance provider to complete dental claims presented to your insurance provider, to process and collect payment of accounts, and to comply with audit procedures that may be needed to comply with legal and business requirements.

**MISSED APPOINTMENTS AND LATE CANCELLATIONS:** The appointment date and time scheduled for a Patient at our practice is reserved exclusively for you. We do our best to keep on schedule and to keep wait time to a minimum. To make this possible, we ask that you be on time for your appointment. As a courtesy to our Patients we do not "double book" appointments. For this reason, you may be charged for missed appointments and late cancellations without good reason.

**FEES AND INSURANCE COVERAGE:** Patients are responsible for the cost of their treatment. Unless otherwise agreed, payment is generally made at the time that the service is provided. The fees charged in this office are those contained in the Fee Guide of the Canadian Dental Association.

Following your treatment, our staff submits an Insurance Claim on your behalf to your insurance company electronically using the CDA Net. You can expect to receive payment from your insurance company within 3 to 5 business days following your treatment. I understand that regardless of insurance claims that I am ultimately responsible for and agree to pay any outstanding balance for services provided.

**Authorization for Electronic Submission of Claims:** I hereby authorize the release, to my dental plans administrator and the CDA of information contained in claims and predetermination of insurance submitted electronically. I also authorize the communication relating to the coverage of services described to Dr. Elon Griffith. This authorization continues until the undersigned revokes the same.

I acknowledge that I have read and understand the Policies and Procedures set out above and hereby agree to them.

Patient's Signature: _____ Date:_____

Intake Staff Name:_____