Midroni
Family Dental Care

PATIENT INFORMATION				
☐ Mr. ☐ Miss ☐ Mrs. ☐ Dr.	Last Name	First Name	Middle Initial	
Unit / Apartment #	Street Address		Birth Date mm/dd/yy / /	
City	Province	Postal Code	Gender ☐ Male ☐ Female	
Home Email Address			☐ Preferred Contact	
Work Email Address			☐ Preferred Contact	
Home Phone ☐ Preferred Contact ( )	Work Phone ☐ Preferred Contact ( )		Cell Phone ☐ Preferred Contact ( )	
Whom may we thank for referring you?				
Family Physician Name	Physician Phone ( )			
Emergency Contact Name		Relationship to You		
Home Phone: ( )	Work Phone ( )		Cell Phone ( )	

INSURANCE INFORMATION				
Do you have dental insurance? ◯ Yes ◯ No		If yes, please provide the following information:		
Primary Insurance Carrier Name:	Subscriber's Name	Subscriber's Birth Date: mm/dd/yy / /	Group Policy/ Plan #:	Certificate/ ID #:
Patient's Relationship to Policy Holder:	☐ Self	☐ Spouse	☐ Child	☐ Other
Secondary Insurance Carrier Name:	Subscriber's Name	Subscriber's Birth Date: mm/dd/yy / /	Group Policy/ Plan #:	Certificate/ ID #:
Patient's Relationship to Policy Holder:	☐ Self	☐ Spouse	☐ Child	☐ Other

I authorize the release of information that is contained in dental claims and predeterminations submitted electronically on my behalf. (Signature) _____

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We provide personalized and professional dentistry in a compassionate & comfortable environment, building upon our trusted patient relationships.

Personalized Service & Care

We are dedicated to provide highly personalized dental care and to meet individual needs. We place emphasis on building long lasting relationships. We attend to our clients in a professional and empathetic manner, from the first appointment to the post-treatment follow-up. Together, we will make your teeth healthier and more beautiful.

Payment Policy

I understand that payment for dental services provided to me or my family is my responsibility, regardless of any insurance coverage that I may have. I assume responsibility for all fees associated with these services and agree to pay for services rendered on the date of the appointment.
For your convenience, our office accepts the following methods of payment:

- Visa
- MasterCard
- Interac/ Debit

Cancellation Policy

Your appointment time has been specifically reserved for you. If for any reason you need to reschedule or cancel your reserved time, we require 2 business days notice; otherwise, it will necessary to charge for the time lost.

Should you have any questions or concerns about our office policies or dental services, please do not hesitate to ask us. We want you to feel comfortable in dealing with these matters and we are here to help you.

Patient's/ Guardian's Signature: _____ Date: _____

Team Member's Signature: _____Date: _____

Submit Form