BANKERS HALL ENDODONTISTS

Name _____
Date of birth: D_____M_____Y_____ Age_____ Gender F M
Home phone _____
Business Ph _____ Email address _____
Home mailing address _____
City _____ Postal code _____
Personal Health Number _____
Occupation _____
Emergency contact _____ Emergency contact's phone # _____
Referred to our office by _____ Your dentist's name _____
Do you see any other dental specialists? _____

We do not accept payment directly from your insurance company but we will assist you in completing your insurance forms and in submitting them on your behalf.

Dental Insurance
(1st carrier) Name of cardholder _____
Name of insurance company _____
Group/Plan # _____ Div # _____ Cert/ID # _____
Employer _____
Relationship to cardholder _____ Cardholder's date of birth D_____M_____Y_____

Dental Insurance
(2nd carrier) Name of cardholder _____
Name of insurance company _____
Group/Plan # _____ Div # _____ Cert/ID # _____
Employer _____
Relationship to cardholder _____ Cardholder's date of birth D_____M_____Y_____

We accept the following forms of payment: Debit card, Visa, Mastercard, Cash
Payment for services is due the day of the appointment.
I understand that I am fully responsible for prompt payment of my account.
_____ Date D_____M_____Y_____
Signature of patient, parent or guardian

Electronic insurance claim submission consent
I authorize release, to my dental benefits plan administrator and the Canadian Dental Association, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.
_____ Date D_____M_____Y_____
Signature of patient, parent or guardian