RAILWAY AVENUE DENTAL

114, 85 Railway Avenue SW, Airdrie AB, T4B 3W9 TEL: 587-360-3062 FAX: 587-360-3067
EMAIL: info@railwayavenuedental.ca www.railwayavenuedental.ca

PERSONAL INFORMATION

Today's Date:_____

Name: (Last)_____(Given)_____(Initial)_____

Date of Birth: (day/month/year)_____Age: _____Male:_____Female:_____

Home Address: _____

City: _____Postal Code:_____Email Address:_____

Phone/Home: _____Business:_____Cell:_____

How did you hear about our office?_____

Alberta Health Care Number:_____Occupation:_____

Dental Insurance

(If for child and dual please list parent born first in the year)

Primary / Name of insurance company: _____

Group/Policy #:_____Certificate Id#:_____

Policy holder (first/last)name:_____DOB:_____

Employer:_____

Secondary / Name of insurance company: _____

Group/Policy #:_____Certificate Id#:_____

Policy holder (first/last)name:_____DOB:_____

Employer:_____

PERMIT FOR OPERATIONS

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of the local anesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's Signature: _____

Parent's Signature (if under 18yrs of age): _____