BAY DENTAL
AT THE POINTE

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____
SS#/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phon_____
Address _____ City _____ State/Prov_____ Zip/P.C. _____
Email _____ Cell Phone_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College _____ City _____ State/Prov. ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer _____ Work Phone_____
Business Address _____ City _____ State/Prov. Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you?
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Re ponsible for thi Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone_____
Driver's License#_____ Birthdate _____ Financial Institutio _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local#_____ Work Phone _____
Address of Employer _____ City _____ State/Prov. Zip/P.C. _____
Insurance Company _____ Group# Policy/ID#_____
Ins. Co. Address _____ City _____ State/Prov. Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State/Prov_____ Zip/P.C. _____
Insurance Company _____ Group#_____ Policy/ID#
Ins. Co. Address _____ City_____ State/Prov Zip/P.C. _____
How much is your deductible? _____ How much have you used?_____ Max. annual benefit _____

Over Please