



Georgia Dental Group

PREVENTIVE & AESTHETIC DENTISTRY

Patient Information

Name: _____
Last First MI (Preferred Name)

Address: _____
Street Apt #
City Province Postal Code

Phone: Home _____ / Work _____ Ext _____ /Cell _____

E-mail: _____ Appointment reminders: ☐ E-mail ☐ Text ☐ Both ☐ N/A

Date of Birth (Year/Month/Day): _____ S.I.N: _____

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City Province Postal Code

Referral Information

How did you hear of our dental practice?

☐ Patient, friend ☐ Patient, relative Whom may we thank for referring you?: _____

☐ Our Website (www.georgiadental.ca) ☐ Google ☐ Google Maps ☐ Other Search Engine ☐ Facebook

☐ Another website: _____ ☐ Specialist/Other Dr.: _____

☐ Ad: _____ ☐ Mail/Postcard ☐ YellowPages.ca ☐ Hotel: _____ ☐ Other: _____

Insurance Information

1) Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Plan Name: _____

Group/Policy #: _____ Division: _____ ID/Certificate#: _____

If patient is not the insured, please complete the following:

Name of Insured: _____ Date of Birth: _____

2) Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Plan Name: _____

Group/Policy #: _____ Division: _____ ID/Certificate#: _____

If patient is not the insured, please complete the following:

Name of Insured: _____ Date of Birth: _____