SANDEEP DHESI
ORAL & MAXILLOFACIAL SURGERY

Demographic Information

Surname: _____ Given Names: _____

Date of Birth (mm/dd/yyyy): _____ Age: _____ Legal Guardian: _____

Mailing address: _____ City: _____ Province: _____

Postal Code: _____ Phone: _____ Work: _____

E-mail address: _____ Cellular: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Common Law

Family Physician, phone number: _____

Referring Dentist, phone number: _____

Provincial Health Care Number: _____ Province: _____

Person Responsible for this account: _____ Relationship: _____

Emergency Contact: _____ Phone: _____

Are you a student? ☐ Yes ☐ No If yes, where? _____

Insurance Information

Primary Insurance

Subscriber's Name: _____ Birthdate (mm/dd/yyyy): _____

Employer: _____ Insurance Company: _____

Group / Policy number: _____ ID or certificate number: _____

Secondary Insurance

Subscriber's Name: _____ Birthdate (mm/dd/yyyy): _____

Employer: _____ Insurance Company: _____

Group / Policy number: _____ ID or certificate number: _____

Authorized Consent to Release Information:
I authorize release to my dental benefits plan administrator information in electronically submitted claims. I also authorize the communication of information related to the coverage of services described to Drs. Kroetsch, Young, Fairbanks and staff.

Patient / Guardian: _____ Date (mm/dd/yyyy): _____