SOUTH
FAMILY DENTAL
General Dentistry

Dr. Angela Sharma
BSc, DMD, DHSc, FRCD(C)
Ph: 403.262.3235
Fax: 403.262.3929

PATIENT INFORMATION

☐ Mr ☐ Mrs. ☐ Miss ☐ Ms. ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Name _____
Last First Middle

Address: _____
City Province Postal Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: (circle) Female Male
dd mm yy

Employer: _____ Occupation: _____

Email:_____ Spouse's Name_____

Are other family members patients at our office: (circle) Yes No

Would you like appointment confirmations via text messaging or email? (circle) Email Text Message

Who can we thank for your referral to our office? (please circle) _____

Family Friend Brochure Newsletter Live Close By Internet Website Signage Other

INSURANCE INFORMATION

Name of Primary Policy Holder	**Date of Birth** dd/mm/yy	**Primary Insurance Company**	**Group Policy Number**	**ID or Certificate Number**
Patient's relationship to policy holder:	Self ☐	Spouse ☐ Child ☐	Other ☐	

Name of Secondary Policy Holder	**Date of Birth** dd/mm/yy	**Secondary Insurance Company**	**Group Policy Number**	**ID or Certificate Number**
Patient's relationship to policy holder:	Self ☐	Spouse ☐ Child ☐	Other ☐	

****PLEASE NOTE: EVERY INSURANCE POLICY IS DIFFERENT AND INSURANCE BENEFIT BOOKLETS ARE GUIDELINES ONLY. IT IS THE RESPONSIBILITY OF THE POLICY HOLDER AND PATIENT TO KNOW YOUR POLICY COVERAGE, NOT THE RESPONSIBILITY OF THE DENTAL OFFICE.**

IMPORTANT CONTACTS

In case of emergency, notify:	Relationship	Phone Number

Family Physician	Clinic Name and/or Address	Phone Number