



6 Sydenham Street | Dundas ON L9H 2T4 | 905-628-6541 | dundas@drchalice dentist.ca
dundasheritagedentistry.com

New Patient Information Form

PATIENT NAME: First Name: _____ Last Name: _____

DATE OF BIRTH (mm/dd/yyyy): _____

CONTACT INFORMATION:

Phone Numbers (circle preferred): HOME: _____

WORK: _____

CELL PHONE: _____

Email Address: _____

Mailing Address: _____

Postal Code: _____

How would you like to receive appointment confirmations and reminders?

Phone Call

SMS Message/ Email

How were you referred to our office? _____





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New Patient Information Form

Name of Physician: _____ Phone Number: _____

Name of Pharmacy: _____ Phone Number: _____

Do you have dental insurance? YES NO

If yes, please provide details:

Name of Insurance Company _____

Policy # _____

Membership ID # _____

PATIENT SIGNATURE: _____ DATE: _____

