

New Patient Registration

Please complete this form in pen and bring it with you to your first visit. One form per patient.

Please do not email this form. Bring it to the office in person. We will also ask you to complete a short health history form when you arrive.

1. Patient information

LAST NAME		FIRST NAME		PREFERRED NAME	
DATE OF BIRTH (YYYY-MM-DD)		CELL PHONE		OTHER PHONE	
STREET ADDRESS AND UNIT		CITY		PROVINCE	POSTAL CODE
EMAIL					
BEST WAY TO REACH YOU ☐ Call ☐ Text ☐ Email					
PREFERRED OFFICE ☐ Milton ☐ Scarborough					

2. Parent or guardian (if the patient is under 18)

FULL NAME	RELATIONSHIP TO PATIENT	PHONE
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3. Dental coverage

COVERAGE ☐ Private / employer insurance ☐ Canadian Dental Care Plan (CDCP) ☐ Paying myself ☐ Not sure		
INSURANCE COMPANY	POLICY / GROUP NUMBER	CERTIFICATE / MEMBER ID
PLAN HOLDER'S NAME (IF NOT THE PATIENT)	PLAN HOLDER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT
SECOND INSURANCE COMPANY (IF ANY)	POLICY / GROUP NUMBER	CERTIFICATE / MEMBER ID

CDCP patients: please bring your CDCP member card or letter. Some services require pre-approval from Sun Life before treatment.

4. Emergency contact

FULL NAME	RELATIONSHIP	PHONE
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5. About your visit

REASON FOR YOUR VISIT

PREVIOUS DENTIST (NAME AND CITY)

APPROXIMATE DATE OF LAST DENTAL
VISIT

HOW DID YOU HEAR ABOUT US? ☐ Google ☐ Friend or family ☐ Social media ☐ Drove by

☐ Other: _____

6. Signature

I confirm the information on this form is correct to the best of my knowledge. I understand that Orion Dental collects this information to register me as a patient, to contact me about appointments, and to bill my dental coverage, as described in the privacy policy at oriondental.ca/privacy-policy.

SIGNATURE OF PATIENT (OR PARENT / GUARDIAN)

DATE

IF SIGNING FOR THE PATIENT: YOUR NAME

RELATIONSHIP TO PATIENT
