Dr J. Kellerstein

REGISTRATION FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name: First: Middle:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	
Home phone no.:	Birth date: MM / DD / YYYY	Age:		Sex: ❑ M ❑ F
Street address:				
City:	Province:			Postal Code:
Occupation:				Work phone no.: ( )
Family Dentist Name:				Dentist Phone No:
Family Dentist Address:				

Chose clinic because / Referred to clinic by:

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RESPONSIBLE PARTY INFORMATION

Our office does not deal directly with the insurance companies. However we will send a predetermination to your insurance company so that you may be informed of your coverage before we proceed with treatment.

Person responsible for bill: **Person(s) to whom we will send correspondence:**	❑ Miss ❑ Ms. ❑ Mr. ❑ Mrs.	Address if different to above:		**Home phone no.:** ( )
Work Phone No.:	( )		**Cell phone No.:**	( )
Is this person a patient here?	❑ Yes ❑ No	Is this patient covered by insurance?		❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge.

Signature of Patient or Guardian:

____Date:______________________________