DENTISTRY @ ROCKLAND

WELCOME TO OUR CLINIC

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

Date: DD_____ MM_____ YY: _____ Medical Alert (office Use only):_____

PERSONAL INFORMATION

First Name: _____ Last Name: _____

Date of birth: DD: _____ MM: _____ YY: _____

Address: _____ City: _____ Postal code: _____

Home Phone:_____ Cell phone: _____Work phone: _____

Email: _____

Referral source: ☐ Google ☐ Flyer ☐Sign outside ☐Other:_____

If child patient, which parent to contact? _____

Mother's name: _____Phone number: _____

Father's name:_____Phone number: _____

(In case on an emergency, contact) Name: _____Phone number: _____

Do you have Any dental insurance? Yes ☐ Or No ☐

Primary insurance company name:_____

Employer: _____

ID Number: _____ Policy Number: _____

Secondary insurance company name:_____

Employer: _____

ID Number: _____ Policy Number: _____

CANCELLATION POLICY:

When you book an appointment with us, we reserve that time specifically for you to see the dentist or hygienist. As such, we require two business days (48 business hours) notice in the event an appointment must be changed or cancelled. This allows other patients awaiting treatment to be rescheduled into the time slot initially reserved for you. **Short notice cancellations (i.e. less than 48-hour notice) and missed appointments will be subject to a broken appointment fee, in the amount of $50, charged directly to the credit card on file.** Life happens and we understand that sometimes you just can't make it for a valid reason. Your credit card will not be charged for a first offense: **if it is for a valid reason. PLEASE NOTE OUR VOICE MAIL DOES NOT ACCEPT CHANGES OF SCHEDULE. Please contact the clinic for any changes to your scheduled appointment.**

Print name: _____

Signature: _____

Date: DD: _____ MM: _____ YY: _____