DR. RICKY SEE & ASSOCIATES

One-Visit Cerec Crowns, Microscopic Dentistry, Invisalign, Laser Dentistry, Dentistry During Sleep

PATIENT REGISTRATION FORM

LAST NAME : _____ **TITLE:** ☐**Dr.** ☐**Mr.** ☐**Mrs.** ☐**Ms.** ☐**Miss.**

FIRST NAME : _____ **DATE OF BIRTH :** mm / dd / yyyy

GENDER : ☐ **M** ☐ **F** **MARITAL STATUS :** ☐ **MARRIED** ☐ **SINGLE** ☐ **OTHERS:** _____

ADDRESS : _____
Number Street Apt.#

_____
City Province Postal Code

OCCUPATION : _____ **EMPLOYER/SCHOOL:** _____

HOME PHONE : (_____)_____ **MOBILE :** (_____)_____

OFFICE PHONE : (_____) _____ **EXT.** _____ **E-MAIL:** _____

MAY WE CALL YOU AT WORK? ☐ **YES** ☐ **NO**

WHAT IS YOUR PREFERRED WAY OF COMMUNICATION WITH OUR OFFICE?
☐ **HOME PHONE** ☐ **MOBILE** ☐ **OFFICE PHONE** ☐ **EMAIL** ☐ **TEXT MESSAGE**
FOR TEXT MESSAGING, SERVICE PROVIDER: ☐ **ROGERS** ☐ **FIDO** ☐ **OTHERS** _____

ARE THERE ANY REASON(S) WHY YOU CHOOSE TO COME TO OUR OFFICE?
☐ **WORD OF MOUTH** ☐ **CLOSE TO HOME/WORK** ☐ **TOTAL DENTAL CARE UNDER ONE ROOF**
☐ **DENTISTRY DURING SLEEP** ☐ **OTHERS:** _____

MAY WE KNOW THE NAME OF THE PERSON, IF ANY, WHO REFER YOU TO OUR OFFICE? _____

ARE ANY OF YOUR FAMILY MEMBER PATIENT OF THIS OFFICE? ☐ **YES** ☐ **NO**

IF YES, NAME : _____

IN CASE OF EMERGENCY, CONTACT : _____

RELATIONSHIP : _____ **PHONE:** (_____)_____

DO YOU HAVE DENTAL INSURANCE COVERAGE : ☐ **YES** ☐ **NO**
(If you have dental insurance and would like to take advantage of our electronic claim submission service, please download and fill out the Insurance Information Form.)

Tel.: (416) 222-2192
Fax: (416) 222-9047

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