WOODSTOCK
Dental and Wellness Centre

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female

Address:

_____

Email: _____ Phone: _____

INSURANCE INFORMATION

◯ No Dental Insurance

Name of Primary Insurance Company: _____

Policy Holder Name: _____ Birth Date: _____

Policy#: _____ Subscriber ID: _____

Policy Holder Address: _____

Name of Secondary Insurance Company: _____

Policy Holder Name: _____ Birth Date: _____

Policy#: _____ Subscriber ID: _____

Policy Holder Address: _____

REASON FOR REFERRAL

Referred by Dr: _____ Dental Office: _____

Referring Treatment: _____

Type of Sedation Required: ◯ **N20** ◯ **Oral Sedation + N20** *(Oral sedation is only available to patients over 18)* ◯ **GA**

X-Rays: ◯ Sent by email ◯ No X-Rays available

MEDICAL HISTORY

Current Medications: _____

Allergies: _____

Relevant Medical History: _____

_____

Height: _____ Weight: _____

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