Riverside Dental Clinic
Patient Address and Insurance Information

Name: _____ Date of Birth: _____

Address: _____ Postal Code: _____

Home No.: _____ Work No.: _____ Cell No.: _____

E-mail address: _____

Occupation: _____ Family Physician: _____

Name and Phone Number of a relative or friend in case of emergency (not residing with you):

_____

Other family members that are patients here: _____

How did you hear about us?
- ☐ Signage/Location
- ☐ Internet/Website
- ☐ Friends/Family: _____

Insurance Information:
Do you have insurance coverage? ☐ Yes ☐ No

Primary Insurance:
Name of Insurance Plan: _____
Name of Subscriber: _____
Date of Birth: _____
Group/Policy No.: _____
Certificate/ID No.: _____

Secondary Insurance:
Name of Insurance Plan: _____
Name of Subscriber: _____
Date of Birth: _____
Group/Policy No.: _____
Certificate/ID No.: _____

Request for Confidential Information
As my dental care provider, you may do the following with my permission:

Contact me at home	☐ Yes	☐ No
Leave messages on my home voicemail	☐ Yes	☐ No
Contact me via cell phone	☐ Yes	☐ No
Leave messages on my cell phone voicemail	☐ Yes	☐ No
Contact me at work	☐ Yes	☐ No
Leave messages on my work voicemail	☐ Yes	☐ No
Contact me via email	☐ Yes	☐ No