WEST MALL DENTAL GROUP
FAMILY DENTISTRY

NEW PATIENT FORM

Your cooperation in completing this questionnaire is essential to provide you with safe and appropriate dental care. All information is strictly confidential. A member of our team will be able to assist you with the completion of this form. PLEASE PRINT.

PATIENT NAME (SURNAME, GIVEN): **PREFERRED NAME:**

BIRTHDATE (DD/MM/YY): SEX: SCHOOL:

HOME ADDRESS (NO, STREET, CITY, PROVINCE): POSTAL CODE:

HOME PHONE: OTHER PHONE: CONTACT EMAIL:

May we leave a voicemail regarding your appointment at these numbers? Yes ☐ No ☐

ARE YOU LIKELY TO BE AVAILABLE ON SHORT NOTICE FOR FUTURE APPOINTMENTS OR CHANGES? Yes ☐ No ☐

We would like to send you email and text communications which may include appointment confirmations, newsletters, upcoming events, and important notifications. Check the box if you would like to receive future email and text communications from us. ☐

FAMILY PHYSICIAN: PHONE:

IN CASE OF EMERGENCY NOTIFY: RELATION: PHONE:

PARENT/GUARDIAN/CAREGIVER 1 INFORMATION:
NAME (SURNAME, GIVEN) RELATION:

ADDRESS (NO, STREET, CITY, PROVINCE): PHONE:

OCCUPATION: WORK PHONE:

PARENT/GUARDIAN/CAREGIVER 2 INFORMATION (IF DIFFERENT THAN ABOVE):
NAME (SURNAME, GIVEN) RELATION:

ADDRESS (NO, STREET, CITY, PROVINCE): PHONE:

OCCUPATION: WORK PHONE:

PLEASE LIST ANY OTHER PERSONS WHO MAY HAVE ACCESS TO THIS FILE (E.g. SCHEDULING APPOINTMENTS):
NAME: RELATION:

HOW DID YOU HEAR ABOUT US?
Referred from an existing patient or staff member (family, friend or colleague), internet, community, professional referral (another health care professional), emergency/walk-in or other:

Office Policy: Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require 48 hours notice, otherwise it may be necessary to charge for the time lost.

(Signature) PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ DATE