Dr. J. Brett Burry and Dr. Emmanuel Karamanis
General and Cosmetic Dentistry
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ACCOUNT NUMBER

Welcome to our office! To enable us to effectively care for you, **please fill out this form completely.**

Whom may we thank for referring you to our office? _____

What influenced your decision to choose our practice for your dental needs?_____

_____

Patient Name _____Birth Date: ____/____/____

Address: _____City: _____ Prov:_____ Postal Code: _____

Home Phone: _____Cell Phone: _____ Message Phone: _____

E-mail: _____ **Contact Preferences:** Text Msg___Email___Home____Cel_l___

Sex: (circle one) Male Female Occupation: _____ Employer: _____

Emergency Contact Name: _____ Phone Number: _____

Responsible Party (Guardian/Parent if patient is a minor)

First Name:_____ Last Name: _____Relationship to Patient: _____

Address: _____City: _____ Prov:_____ Postal Code: _____

Home Phone: _____Work Phone: _____ Ext:_____

Birth Date: ___/____/____ Employer: _____ Occupation: _____

Primary Dental Insurance

Name of Insured: _____ DOB:_____

Employer: _____

Insurance Carrier: _____

Group / Policy Number: _____ Division: _____

ID Number or SIN: _____

Certificate Number: _____

Coverage Percentage: A_____ B_____ C_____

Limits: Basic _____ Major _____ Ortho _____

Deductible: Basic _____ Major _____ PER PERSON ☐ OR FAMILY ☐

Secondary Dental Insurance

Name of Insured: _____ DOB:_____

Employer: _____

Insurance Carrier: _____

Group / Policy Number: _____ Division: _____

ID Number or SIN: _____

Certificate Number: _____

Coverage Percentage: A_____ B_____ C_____

Limits: Basic _____ Major _____ Ortho _____

Deductible: Basic _____ Major _____ PER PERSON ☐ OR FAMILY ☐

I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature of Patient, Parent, or Guardian: _____ Date: _____