ILDERTON
DENTAL CARE

Download this file and open it in a compatible PDF reader. Enter your answers, save a copy, then upload it through the enabled return option or bring it to your appointment. Saving the PDF does not send it to the clinic. A completed copy contains personal health information: keep it on a trusted device. If your PDF app can't save, print the form and fill it in by hand.
Dates: YYYY-MM-DD (for example 2026-10-01). Leave anything you'd rather discuss in person; a blank is not a "No".

Patient

First (given) name

Middle name or initial

Last (family) name

Name you prefer to be called

Birthdate (YYYY-MM-DD)

Email

Street

Apt. #

City

Province or state

Postal code

Country

Home phone

Work phone

Work extension

Safest way for the clinic to contact you ○ Home phone ○ Work phone ○ Email

Occupation

Are you a student? ○ Yes ○ No

School

Whom may we thank for referring you?

Do you have a spouse or partner you'd like on file? ○ Yes ○ No

Spouse's name

Is someone helping with or representing the patient (e.g. parent, guardian, substitute decision-maker)? ○ Yes ○ No

Parent/Guardian name

Relationship to patient

Any other family members in our practice? ○ Yes ○ No

If yes, whom

Roles

Who is filling in this form?
○ The patient ○ Someone helping

Helper's name

Helper's relationship to the patient

Does someone else have legal authority to make health-care decisions for the patient? ○ Yes ○ No ○ Not sure

Decision-maker's name

Their role (for example parent, guardian, power of attorney)

Emergency

Emergency contact name

Relationship to patient

Home phone

Work phone

Work extension

Other phone

Signature

Signing: type your full name below, or print this page and sign by hand. A typed name is not a certified digital signature; you can also sign at the clinic.

Signature of patient or parent/guardian

Date (YYYY-MM-DD)

Coverage

Coverage is decided by your plan, not the clinic. For CDCP applications and eligibility, visit Canada.ca.

How will your dental care be covered? Choose all that apply.

- ☐ Private or workplace insurance
- ☐ Canadian Dental Care Plan (CDCP)
- ☐ Other government coverage
- ☐ Self-pay / no coverage
- ☐ I'm not sure

Primary

Primary subscriber first name

Initial

Primary subscriber last name

Phone #

Address

Birthdate (YYYY-MM-DD)

Insurance Co.

Policy/Plan #

Identification #

Employer

Separate policy

Are you also covered by a separate policy (for example, through a spouse, partner or parent)?

○ Yes ○ No

Subscriber first name

Initial

Subscriber last name

Birthdate (YYYY-MM-DD)

Insurance Co.

Policy/Plan #

Identification #

Employer

Other

Which government program?

Payer

Who will pay any balance not covered?

○ The patient ○ The insurance subscriber ○ Someone else ○ Not sure

Name of the person paying

Acknowledgements

☐ I authorize release, to my insurance company/plan administrator, the information contained in claims submitted electronically.

Continuation page

Use this page if any answer needs more room. Write the question it continues.