North Hill Denture Clinic 261B, 1632 14-Ave.NW, Calgary, AB T2N 1M7

Personal Information: **PLEASE PRINT CLEARLY and place an "X" into the appropriate box (es)**

Mr. Mrs. Ms.
Miss _____ Date of birth: ____/____/____/
Last name First Name used Month Day Year

Alberta Health Care # _____ - _____ Gender: ☐ Female ☐ Male

Address _____ City _____ Postal Code _____

Daytime contact# (____) _____ Cell: (____) _____ **email:** _____
(For appointment reminders)

Home: (____) _____

Dentist _____ Doctor _____

How did you hear about NHDC? _____ **First time as client to NHDC? YES☐ NO ☐**

Legal Guardian (if applicable): _____ Contact numbers _____

In Case of Emergency: NAME: _____ Contact numbers _____

Relationship: _____

Individual Responsible For Account: ☐ Client ☐ Guardian ☐ Insurance and Client ☐ Insurance and Guardian

Insurance Carriers

Primary: _____/_____/_____/_____
Carrier / Government Agency Group / Plan # Certificate / ID #

Name of Subscriber: _____ Date of birth: ____/____/____/
Mo Day Year

Place of employment: _____ Relationship to client: _____

Secondary: _____/_____/_____/_____
Carrier Group / Plan # Certificate / ID #

Name of Subscriber: _____ Date of birth: ____/____/____/
Mo Day Year

Relationship to client: _____

I acknowledge that all my information has been collected for use according to the requirements of the PIPA (Personal Information Protection Act) and authorize the use of it to create my file and to collect payment for services.

I authorize release, to my benefits plan administrator, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named denturist. I hereby assign my benefits payable from claims, electronically submitted, to the North Hill Denture Clinic. This authorization shall continue in effect until the undersigned revokes the same.

_____ Dated: _____
Signature of client

Form by MIF