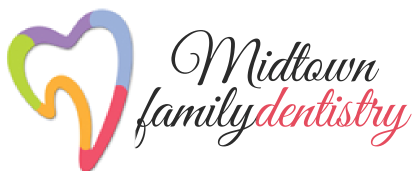

1849 Yonge Street,
Suite 513,
Toronto, ON M4S 1Y2
(416) 483-3530
Email: info@drtmagus.com

General Family Dentistry: Dr. Teresa Magus

WELCOME TO OUR DENTAL OFFICE. Your cooperation in completing this form is essential to providing you the highest standard of dental care. All information is strictly confidential and will remain within this office. Our reception team members are available to assist you with the completion of this form. **Please Print.**

The patient is an:ADULT☐ CHILD☐ ADULT UNDER GUARDIANSHIP☐ NAME OF GUARDIAN ____________________

CONFIDENTIAL PATIENT INFORMATION

PATIENT'S NAME Last First Middle	DATE OF BIRTH (MM/DD/YY)	Gender ☐ F ☐ M

PATIENT'S ADDRESS	Home Phone #	Cell phone #	Work Phone #
	By which way do you prefer to communicate with us? (Check more than one choices if necessary) ☐ Home # ☐ Cell # ☐ Work # ☐ Text ☐ Email		

MARITAL STATUS	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

EMAIL ADDRESS (Your email address will be in confidence and only used for office communication with you)

SPOUSE'S NAME Last First Middle	SPOUSE'S EMPLOYER	OCCUPATION

PERSON WE CAN CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME: **RELATIONSHIP:** **WORK NO.** **HOME NO.**

HOW DID YOU HEAR ABOUT US?

☐ FRIENDS/FAMILY (Please Name so we can thank them :____________________) ☐ Internet (Website, facebook) ☐ Drive- By

☐ Phonebook (please name if known: ____________________) ☐ Newspaper (please name if known: ____________________)

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask any questions and receive answers to any questions regarding my medical-dental history. I realize that the dentist is a general practitioner who offers many specialized treatments to patients. Should there be any change in my health status in the future, I will advise this dental office.

I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my doctor or another health care provider may be necessary.

I consent to the responsibility for payment of the dental services for myself and my dependents is mine solely and I assume responsibility for fees associated with these services. I understand this office requires **24 hour** notification to avoid any minimum charges.

Patient's or Guardian's Signature ______________________________ **Date** ____________________