Personal Information

Name____

Parent or guardian name (if applicable) ____

Date of Birth ___________/_________/____________
Day Month Year

Address ____

City ___________________________________ Postal Code ________________

Phone: Cell _________________Work _____________________ Home ____________________

Email ____

Occupation ______________________________________ Employer ______________________

Physician ____

Insurance Information

Insurance Carrier _______________________________________

Policy # ______________________________________ Certificate # _________________________

Name of policy holder ____

Birth date of policy holder ____________/_________/__________
Day Month Year

Health card # ____

How did you find out about our clinic? ____

Phone 902-865-8121
190 Cobequid Rd, Lower Sackville, NS B4C 2N4
Info@sackvillesmilecentre.ca
Fax 902-864-6069

Sackville Smile Centre

Dr. Lyn Fitzpatrick DDS

Please read the following notes about our office policy. In order to avoid any misunderstandings we would like you to know the following:

☺ We would like to make your dental experience as comfortable as possible for you so if there is anything that you can think of that would help you have a better experience please don't hesitate to ask.

☺ Dr. Fitzpatrick is available for after hour emergencies. The number to reach her is 902-430-6134. It is also available on the answering machine should you require it.

☺ We are happy to assist you with your dental insurance claims.

☺ In order to reduce the amount of administrative paperwork, all patients are expected to pay for their treatment or any portion not paid for by insurance carrier on the day that it is provided.

☺ For all dentures, crowns and bridgework, 50% must be paid at the time the material goes to the lab for processing and the remainder at the time of delivery. **If you wish to pay in full for this treatment at the initial appointment we would be happy to offer you a 5% discount. (Please ask Lynda for details).**

☺ 24 hours notice is required for all cancellations otherwise a $80.00 fee may apply.

Please read and sign the following:
I hereby allow the use of my personal information by Dr. Lyn Fitzpatrick in order to allow communication to other healthcare providers or my insurance company. I know this will be the sole purpose for the sharing of this information.

Signature____Date___________

Patient certification and approval for medical history:
I the undersigned, certify that all of the medical history and dental information I will provide is true to my knowledge and I have not omitted any pertinent information. I consent to the performing of dental procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated. I will assume the fees associated with these procedures.

Patients (Parent or guardians) signature____________________Date_____________