

CORONATION DENTAL SPECIALTY GROUP REGISTRATION

Please complete information, print, and bring to your 1st appointment

First Name: Last Name: Birth Date:
Address: City: Postal Code:
Home: Business: Mobile:
email: Preferred: Home Business
Mobile email
HealthCard # Version Code Expiry
Dentist Name Physician Name

Next of Kin &
contact info

PRIMARY INSURANCE (Subscriber's Info as shown on card) Name

Employer: Insurance Company
Policy/Group # Certificate # Birth Date

SECONDARY INSURANCE (Subscriber's Info as shown on card) Name

Employer: Insurance Company
Policy/Group # Certificate # Birth Date
Full-time student? If yes; School

PARTY RESPONSIBLE FOR ACCOUNT Patient is responsible party (check if same as section 1)

Name Relationship to patient
Employer Date Birth
Name Relationship to patient
Employer Date Birth

Payment is required as treatment is rendered. If payment is not received by Coronation Dental Specialty Group, an interest charge of 18% per annum (1.5% per month) will be added to this account if 30 days or more past due.

I authorize release of information transmitted electronically to my dental plan administrator

Signature Date