Dr. Dan Dagasso
ORTHODONTICS

DATE: _____

**Dr. Dan Dagasso** BSc, DMD, MCID, FRCD(C)
BC Certified Specialist in Orthodontics and Dentofacial Orthopaedics

## PATIENT INFORMATION:

PATIENT NAME: _____

PATIENT AGE: _____ BIRTHDATE (M/D/Y): _____ ☐ MALE ☐ FEMALE

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

DENTIST: _____ PHYSICIAN: _____

Who may we thank for referring you?: _____

## ACCOUNT INFORMATION (Person responsible for account):

☐ Mrs. ☐ Mr. ☐ Ms. ☐ Dr. _____ EMAIL ADDRESS: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

**DENTAL INSURANCE:** We do NOT bill dental insurance companies directly. Payment from the responsible party is required at the time the services provided. We will aid you with preparing your insurance claims so that you may receive reimbursement directly from your insurance company.

NAME OF POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

BIRTHDATE (M/D/Y): _____ EMPLOYER: _____

INSURANCE COMPANY: _____ GROUP: _____

ID/CERTIFICATE: _____ PATIENT DEPENDENT NUMBER: _____

% ORTHO COVERAGE: _____ COVERAGE LIMIT: _____

NAME OF POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

BIRTHDATE (M/D/Y): _____ EMPLOYER: _____

INSURANCE COMPANY: _____ GROUP: _____

ID/CERTIFICATE: _____ PATIENT DEPENDENT NUMBER: _____

% ORTHO COVERAGE: _____ COVERAGE LIMIT: _____