DR. TRUDY L. CORBETT
CERTIFIED SPECIALIST IN PERIODONTICS

PERSONAL HISTORY

Mr. Mrs. Ms. Dr.

Patient Name_____
First Middle Last

Address: _____ Phone:_____(H)

_____ _____(W)
City Province Postal Code

Email Address:_____

Date of Birth: _____ Occupation: _____

Parent or Guardian (if under 18):_____ Phone: _____ (H)

_____ (W)

Emergency Contact: _____

Name of Dentist: _____

Whom may we thank for referring you to this office? _____

Physician: _____

Address: _____

Phone: _____

FINANCIAL RESPONSIBILITY

Payment is required at the time service is rendered. We are happy to provide you with an estimate. You may pay your account by Cash, Visa, MasterCard, American Express, Debit, Cheque or Post-Dated Cheque. The following dental insurance information helps us assist you in better utilizing your insurance benefits.

Do you have dental insurance? YES NO

Insurance Carrier Name: _____Group No._____ ID No. _____

CONSENT

I authorize the dental personnel to perform services for the prevention, diagnosis and treatment of periodontal disease using the procedures and medications required, and assume responsibility for the fees associated with these procedures.

Date:_____ Signature of Patient or Parent:_____