Dr.Christie Laberge
BSc, BSc(Dent), DMD, MSc(Ortho) FRCDC

WELCOME TO OUR OFFICE

Patient's name ___________________________ ___________________
Surname Given Name

A dental insurance policy is a contract between you and the insurance company. Our professional services are rendered and charged directly to the patient's account. The person responsible for the account is responsible for payment of all fees incurred. We will gladly assist you in submitting insurance claims pertaining to any charge for care in our office.

If you have more than one insurance carrier please indicate who is the primary insurance carrier. The primary carrier is the person whose birthday is first in the calendar year.

Primary Insurance

Surname Given Name

Address____
(If different from patient)

City ______________________Province_____________

Postal Code ________________

Phone _____________________ Work_______________

E-mail ____

Birthday (M/D/Y) ____/____/____ Sex: M F

Secondary Insurance

Surname Given Name

Address____
(If different from patient)

City ______________________Province_____________

Postal Code ________________

Phone _____________________ Work_______________

E-mail ____

Birthday (M/D/Y) ____/____/____ Sex: M F

Insurance Company __________________

Policy/ Plan # ________________________

Subscriber/Certificate # _______________

Insurance Company __________________

Policy/ Plan # ________________________

Subscriber/Certificate # _______________

Parent/Patient signature ____ **Date** _______________________

Thank you for your patience in filling out this form. It will help us create proper forms for you to be reimbursed from your insurance carrier.