Community Dental
ACCESS CENTRE

Today's Date: _____

Patient Intake Form

Name: _____

Date of Birth: _____

Care Card #: _____

Address: _____

City: _____ Postal Code: _____ No Fixed Address: ☐

Home Phone: _____ Cell Phone: _____

Cell Phone Texting: Yes ☐ No ☐ Email: _____

Contact Person's Name: _____

Contact Person's Phone: _____ Email: _____

In pain? Yes ☐ No ☐ On Waitlist: Yes ☐ No ☐

Last Dental Visit: _____

Who referred you?: _____

Main Concern: _____

Appointment Date/Time: _____

Financial Assessment Completed: Yes ☐ No ☐ Approved: Yes ☐ No ☐

Insurance Plan:

MSD ☐	H Kids ☐	Disability ☐	NIHB ☐	DVA ☐
Social Services	Premium Assistance	PWD	First Nations	Veteran Affairs

Insurance Carrier: _____

Group # _____ ID # _____ Dep # _____

Insurance Limitations: _____