Dr. Marvin Gretzinger

Tel: 519-886-1931 Fax: 519-886-1612 Email: mcgretzdds@gmail.com
Suite 204, 255 King Street N, Waterloo, Ontario, N2J 4V2

Patient Consent and Insurance Form

About You

Name _____ Age _____ Date of Birth _____

Address _____ City _____ Postal Code _____

Home Phone _____ Work Phone _____

Occupation _____ Employer _____

Family Connection

Parent/Guardian/Spouse _____ Relationship _____

Address _____ City _____ Postal Code _____

Home Phone _____ Work Phone _____

Whom may we thank for referring you? _____

Insurance Information

Subscriber's Name _____ Date of Birth _____

Employer _____ Insurance Company _____

Group # _____ ID # _____

Please help us to maintain the operation of our office on sound principals so that we might assure you and our other patients of uninterrupted treatment. Remember that once you have made an appointment, that time is reserved for you. Therefore, at least 48 hours of notice must be given if cancellation is absolutely necessary, otherwise there may be a charge and a delay in treatment may develop.

I understand that I am financially responsible for the entire cost of my dental treatment at time of treatment.

Patient (Parent) Consent

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic and nitrous oxide analgesia as indicated and I will assume responsibility for fees associated with those procedures.

Signature _____ **Date** _____