TUDOR GLEN
SMILE CLINIC
ST. ALBERT

Patient Information Form

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Legal Name: Yvette Cioran

Date of Birth: _____ Home Phone: _____

Address: _____ Mobile Phone: _____

_____ Work Phone: _____

Postal: _____ Email: _____

City: _____

Emergency Name: _____ Phone: _____

Contact Preference

Prefer to be Contacted by:	☑ Phone Call	☑ Text Message	☑ Email	☑ Post	☑ N/A
Please, DO NOT Contact by:	☐ Phone Call	☐ Text Message	☐ Email	☑ Post	☑ N/A

Insurance Information

☑ No Insurance ☑ Health Spending ☑ Prefer to Submit on Own

Policy Holder: _____

Date of Birth: _____

Insurance Company: _____

Plan Number: _____

ID Number: _____

Date: _____

Signature/Guardian Signature: _____

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