Groupe dentis

□ **DR. DÉRY** □ **DR. Samir** □ **DRE Maude Couillard St-Pierre** □ **MICHEL BOSSÉ D.D.**

Name: _____

*Legal representative/Parent/Guardian: _____

Insurance:

Do you have dental insurance? Yes: _____ No: _____

Are you on the Social Solidarity Program? Yes: _____
(*If yes, we need your claim slip of the current month and your health insurance card valid*)

What's the best way to reach you?

Home: ( )	Work: ( ) Ext.:
Cell Phone: ( )	E-mail:

***IF YOU WANT TO BE ADVISED FOR YOUR APPOINTMENTS BY TEXT OR E-MAIL, WRITE YOUR CELL NUMBER AND/OR YOUR E-MAIL ADDRESS.**

Please note that we do not accept checks or American Express.

*** PLEASE NOTE THAT THERE WILL BE **ADDITIONAL FEES FOR ANY MISSED OR CANCELED APOINTEMENT WITHOUT NOTICE OF 48 HOURS WORKING DAY**: **$50**/HOUR WITH HYGIENIST, **$100**/HOUR WITH DENTIST.

I agree that photographs, x-rays, and models may be shared for interprofessional consultation purposes, or for public and professional education. Any information that may identify me will be erased so as to protect my identity.

SIGNATURE : _____ DATE : _____/_____/_____