



120-40 Lakewood Boulevard
Winnipeg, MB R2J 2M6

Dr. Doug McDermid, DMD
Dr. Rose Dhillon, DMD

PATIENT REGISTRATION

Patient Information | (Please Print)

First Name Last Name Middle Initial

Address

City Province Postal Code

Home phone Work phone Mobile E-mail

Date of birth Age Gender

Name of person to contact in case of emergency Home phone Work phone Mobile

Physician's name Phone

How did you find our office? (Referral source)

Insurance Information (Please provide insurance card)

Name of insured: _____
Relationship to patient (Self, Spouse, Child, or Other): _____
Insured date of birth: _____ Employer: _____
Insurance Company: _____ Group #: _____
Certificate/ID#: _____

Secondary Insurance Information (Please provide insurance card)

Name of insured: _____
Relationship to patient (Self, Spouse, Child, or Other): _____
Insured date of birth: _____ Employer: _____
Insurance Company: _____ Group #: _____
Certificate/ID#: _____

I understand that an electronic copy of my signature and the information I have provided will be created. This electronic copy will serve as a genuine copy of my original signature and may be used in place of original for any purpose.

Signature Date

Witness