Dr. Diya Chadha
Certified Specialist - Restricted to Pediatric Dentistry

Dr. Karim Kanani
General Dentist
Certificate in Pediatric Dentistry
University of Rochester, 2014

SmileTown Dentistry

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Patient Information

How did you hear about us?: _____

Patient: _____ _____ SEX: M / F Birthdate: ____/____/____
(FIRST) (LAST) MM DD YYYY

Home Address: _____City: _____Postal Code: _____

Personal Health Number (MSP): _____ Home #: _____

Mother/Guardian: _____ _____ Birthdate: ____/____/____
(FIRST) (LAST) MM DD YYYY

Cell #: _____ Work #: _____Email: _____

Father/Guardian: _____ _____ Birthdate: ____/____/____
(FIRST) (LAST) MM DD YYYY

Cell #: _____ Work #: _____Email: _____

Emergency Contact (other than parents):

Name: _____ Relation: _____ Cell #: _____

Patient Insurance Information

Primary Coverage:

Policy Holder Name**:** _____ _____ Birthdate: ____/____/____

Insurance Co. : _____ Group/Policy #: _____ Certificate/ID#: _____

Secondary Coverage:

Policy Holder Name: **:** _____ _____ Birthdate: ____/____/____

Insurance Co. : _____ Group/Policy #: _____ Certificate/ID#: _____

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

I understand, as a courtesy service, the office will accept payment from all dental plans (unless specified by the policy) and any portion that the dental plan does not cover is the responsibility of the plan holder/parent/guardian, and is due when services are rendered.

I hereby assign my benefits, payable from claims submitted electronically, to Dr. K. Kanani & associates and authorize payment directly to him/her. This authorization shall continue in effect until the undersigned revokes the same.

Signature of parent or guardian/policy holder: _____ **Date:** _____