

Dr. Arlene F. Caringal & Associates

**Date:**

REGISTRATION FORM

**Name:**

(Please Print)

Date of Birth:

Address:

Cell Number: Home:

E-mail Address: How did you hear about us? (Please specify) Do you have insurance? YES (If yes, please present your card to the reception)

**NO**

***Note: WE DON’T DO DIRECT BILLING TO THE INSURANCE. WE WILL FILE THE CLAIM ON YOUR BEHALF AND INSURANCE WILL PAY YOU ACCORDING TO YOUR BENEFITS.***

I certify that the above information is true and correct.

(Signature of Patient / Guardian)

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