Kelowna Dental Centre

Dr. Michael Webster D.M.D & Associates

Patient Information

Name
Last _____ **First**_____ **Middle**_____

Legal name (if different from above) _____

☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Date of Birth _____ **Age**_____ ☐ **Male** ☐ **Female**
(D/M/Y)

Email_____

Cell# _____ **Home#** _____**Work#**_____ **ext** _____

Address_____ **P.O.** _____

City_____ **Prov**_____ **Postal Code**_____

Occupation_____**Employer**_____

Emergency Contact name_____ **Phone** _____

Relationship to Contact _____

What brought you to Kelowna Dental Centre: ☐**Radio** ☐ **Website** ☐ **Newspaper** ☐ **Yellow Pages**

☐ **Family** _____ ☐ **Friend** _____ ☐ **Other** _____

Other family members seen here_____

How would you rate your anxiety level when coming to the dentist?

1	2	3	4	5	6	7	8	9	10

No anxiety **Extreme Anxiety**

Appointment Policy

We require a minimum of 2 business-days notice to make a change to any appointment.
You MUST phone the office, as we do not accept changes by text or email.
Fees will apply without proper notice.
I am aware of and agree to the above_____ (please initial)

Entered _____ Scanned _____ Imported _____

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Please Initial

☐ **I certify that I have read and understand these forms and the information I have provided is correct. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I am responsible to update the Kelowna Dental Centre of any medical / health changes as well as contact and insurance information.**

☐ **I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.**

☐ **I authorize the request to obtain my medical / dental related records and the release of my medical / dental records for the purpose of diagnosis and/or treatment**

☐ **Payment is due at the time of treatment. Major and /or custom work requiring the services of an outside lab will require a deposit equal to the estimated lab fees. I accept full responsibility for this account and agree to pay in full for all services rendered on my behalf or on behalf of my dependants.**

Private Insurance Policy Holders ** PLEASE ASK FRONT DESK FOR INSURANCE FORM**

☐ ****I have signed the Insurance disclaimer and provided current policy information. It is MY responsibility to notify KDC of any changes to my coverage. Kelowna Dental Centre does not directly receive any coverage details from my provider. Any specific information must be provided by me – the policy holder.**

☐ **I authorize the Kelowna Dental Centre to file insurance claims as a courtesy on my behalf and to provide the relevant information in order to process claims. I understand this service is in no way a guarantee of payment and claims not settled by my private insurance within 90 days are my responsibility to pay.**

Patient Name

_____

Please print

Guarantor's Name_____
(if different from patient)

Signature_____

Date_____

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DENTAL INSURANCE INFORMATION

PRIMARY Insurance_____ **Employer**_____

Policy Holder's Name _____ **Policy Holder's Date of Birth** _____

Group No _____ **ID/Certificate/Student** _____

Patient's relationship to subscriber ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

_____

SECONDARY Insurance_____ **Employer**_____

Policy Holder's Name _____ **Policy Holder's Date of Birth** _____

Policy Holder Address _____

Group No _____ **ID/Certificate No**_____

Patient's relationship to subscriber ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Insurance Disclaimer

The contract for dental benefits is between you, your employer and your insurance company. The dental provider is an outside party and we do not receive any information about your policy.

It is important for you to have a copy of your policy and an understanding of your coverage prior to your treatment. This policy is unique and custom tailored based on what your employer is willing to pay in premiums. NO policy is designed to cover all fees.

As a courtesy to our patients, we are happy to submit claims to your insurance provider on your behalf for up to TWO (2) plans. This is not a guarantee of reimbursement. The insurance company has the right, based on your plan to exclude certain procedures or fees.

I acknowledge claims will be processed using information provided by me, on file at the time of processing. I realize this does not guarantee reimbursement and that I am responsible for any balance for services provided, not covered by my private insurance within 90 days.

I understand that my co-payment (or the estimated portion) is DUE AT TIME OF TREATMENT.
Lab fees for major restorative services are due at the ONSET of treatment.

I have read and understand the information contained herein. I accept full responsibility for this account and agree to pay in full for all services rendered on my behalf or on behalf of my dependants including insurance claims not paid within 90 days of service.

Signature _____**Name (Printed)**_____

Date _____