Dr Kelly Kosheiff
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info@kootenaylakedental.ca

PATIENT NAME		EMAIL	
DATE OF BIRTH		PHONE	
PERSONAL HEALTH NUMBER		ADDRESS	
PARENT / GUARDIAN (if minor)			

DENTAL INSURANCE	PRIMARY	SECONDARY
POLICY HOLDER NAME :		
POLICY HOLDER DOB:		
INSURANCE COMPANY :		
EMPLOYER :		
POLICY NUMBER :		
PLAN NUMBER :		

INSURANCE AND FINANCIAL POLICIES	YES	NO
I acknowledge payment is expected at the time of treatment.		
I acknowledge that I am expected to know the coverage limits of my insurance policy.		
I acknowledge that I am responsible for payments not covered by insurance		
I acknowledge dental insurance providers will not supply our office with any details concerning coverage. Insurance benefits are determined by the individual policy and carrier. We do not know if your insurance provider will cover the prescribed treatment		

CONSENT and PRIVACY	YES	NO
I consent to the diagnosis and treatment of conditions related to my dental and oral health by means deemed necessary. This includes acquiring records such as X-rays, study models and/or images. An informed discussion of treatment options including risk/benefit will be carried out prior to the provision of treatment		
I understand that all personal and medical information will be kept private and confidential and only used for the provisional of dental care, and these records are kept secure.		
I understand we may communicate with other health care providers, legal providers and insurance providers on your behalf for the purposes of providing optimal care		
I consent to our office contacting me by the way of email and/or text message. For the purpose of appointment confirmations or otherwise		

CANCELLATION POLICY	YES	NO
I understand we require 48 hrs notice for cancellations. Late cancellations or no-shows may result in a fee of $100		

PATIENT OR GUARDIAN SIGNATURE		DATE	