250-862-3070
INFO@BURTCHDENTAL.COM
#9-1455 HARVEY AVENUE
KELOWNA BC V1Y 6E9

WELCOME TO BURTCH DENTAL

PERSONAL INFORMATION

Name:_____

Address:_____

City:_____ Postal Code:_____

Date of Birth:_____ Employer:_____

Best Phone #_____ Email:_____

Emergency Contact:_____ & Phone # _____

How did your hear about our office?_____

DENTAL INSURANCE INFORMATION:
Policy/Group#_____ ID/Cert #_____
Insurance Company:_____ Name of Insured:_____
Coverage: Basic:_____% Major: ____% Annual Limit: $_____
Frequency of Preventative Care (Recall Exams/Cleanings) 6 9 12 months (circle one)

FINANCIAL
Payment is expected in full for services rendered at the time of appointment. We will accept assignment of dental insurance payments but we do not accept responsibility for the limitations and agreements of your dental coverage. You will be billed directly for all remaining costs not covered by your plan.

OUR OFFICE POLICY ON INSURANCE COMPANIES
There are hundreds of insurance companies and we are not linked directly to them. At your first appointment we enter in the computer the insurance information that you provide us. With the privacy act, most insurance companies will not talk to dental offices about your coverage. It is important for you, the policy holder to know what your coverage and limits are. As a courtesy, we submit claims on your behalf to your dental plan, we do not accept responsibility of the limitations, deductibles and agreements of your plan. You will be billed directly for all remaining costs not covered by your plan. We are happy to send pre-approvals to your insurance for treatment if you require, but the response will usually be sent to you.

I give my consent that BURTCH DENTAL can submit my insurance claims and pre-authorizations by CDANet or call my insurance on my behalf. I have read and understand the office policy on insurance and will pay what my insurance company does not cover.

PATIENT SIGNATURE:_____ DATE:_____