BURTCH DENTAL

250-862-3070
ADMIN@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 you hear about our office?_____

Do you have dental insurance?_____

FINANCIAL

Payment is expected in full for services rendered at the time of your appointment. We will accept assignment of dental insurance benefits, 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

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.

We have a 24 hour cancellation policy for changes and rescheduling appointments. If 24 hours is not given or an appointment is missed there will be a $50.00 charge.

Patient Signature:_____ Date:_____