Pewarchuk Dental Clinic, 633 Goldstream Ave., Victoria, British Columbia V9B2W9

WELCOME and THANK YOU for selecting our office for your dental healthcare needs! We will make every effort to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out these forms – and let us know if you have any questions or need assistance. We will be happy to help! Dr. Pewarchuk DDS.

FullName(Dr/Mr/Mrs/Ms)_____
Prefer_____
Gender: M F Marital Status: _____ No. Children_____
Birthdate_____Age_____ Social Insurance #_____
Address_____
_____

Phone: Home ( )_____ Work ( )_____ Ext_____
Cell ( )_____
E Mail_____

Employer_____
Occupation_____
EmployerAddress_____
Street / Suite City Postal Code
Emergency contact name & phone number
_____
By whom were you referred?_____
Family members we have seen_____
Are you covered by Dental Insurance? _ Yes_____ _No_____
Person Responsible for Account_____
Relationship to Patient_____

SPOUSE or LEGAL GUARDIAN INFORMATION ___ Spouse ___ Legal Guardian

Full Name (Dr/Mr/Mrs/Ms)_____
Prefer_____
Gender: M F Birthdate_____ Age_____
Soc.Ins.#_____
Phone: Home ( )_____ Work ( )_____
Ext_____
Cell ( )_____
E-Mail_____
Employer_____
Occupation_____
Employer
Address_____

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PATIENT INFO Name_____
Date_____

DENTAL INSURANCE INFORMATION

Coverage is (Check or circle all that apply): _My policy_ Spouse, who IS / IS NOT a patient here

PRIMARY INSURANCE POLICY

Policyholder's Name_____
Subscriber ID#_____
Ins. Co._____
Phone ( )_____
Group Plan_____ Group#_____

SECONDARY INSURANCE POLICY

Policyholder's Name_____
Subscriber ID#_____
Ins. Co._____ Phone ( )_____
Group Plan_____ Group#_____

I understand and authorize **RELEASE OF INFORMATION** relating to dental claims required by my insurance companies.
I authorize **payment** directly to this office of the insurance benefits otherwise payable to me.
I understand and authorize **RELEASE OF INFORMATION** to other healthcare practitioners to whom I may be referred.
I understand and authorize that **PAYMENT** for services is due in full at the time of service unless arrangements have been approved in advance of work.
I understand and authorize that **FINANCE CHARGES** will be applied to balances 30 days past due from the date of service, including all amounts owed by insurance.
I understand and authorize that **I AM ULTIMATELY RESPONSIBLE** for all costs of dental treatment.
I have answered these questions to the best of my ability and will **NOTIFY THE OFFICE OF ANY CHANGES** in this information at the earliest possible time.

These **AUTHORIZATIONS** are valid until rescinded in writing or replaced by one of a later date.

Patient Signature_____
Date_____

Legal Guardian Signature_____
Date_____
Responsible for account