Driftwood Health Services Inc.
10-2401 Cliffe Avenue
Courtenay, BC V9N 2L5

All Patient Information is Strictly Confidential

Name:_____Address: _____

Home Phone #: _____ _____
City / Province

Work Phone #: _____ _____
Postal Code

Cell Phone #: _____ Date of Birth: _____
Day / Month / Year

Email: _____ MSP CareCard No. _____

Marital Status: Married ____ Single ____ Common Law ____ Widowed ____

How did you hear about us? Radio ☐ Newspaper ☐ Yellow Pages ☐ Internet ☐

Family/Friend ☐ Who?: _____

Do you experience anxiety or become tense during dental appointments? ☐ Yes ☐ No

Would you like to be on our short notice appointment list? ☐ Yes ☐ No

Driftwood Dental sends email and text communications which may include appointment confirmations, newsletters, upcoming events and important notifications. Check the box if you would like to receive future email and/or text communications from us**.** **☐ Yes ☐ No**

INSURANCE: In order to prevent misunderstandings about dental insurance, please note that all professional services provided are the financial responsibility of the patient or legal guardian. By initialling here _____ I give permission for Driftwood Dental to submit my claim electronically or contact my insurance provider on my behalf. Be aware, due to privacy laws, we have limited ability to discuss your claims with your insurance provider. Full payment of the patient portion for treatment is due on the day services are rendered.

APPOINTMENTS: Appointment times are reserved especially for you. If you're unable to attend an appointment please provide two business days notice to avoid a **short notice or missed appointment fee of $50 per hour scheduled**.

PERMISSION TO TREAT: This is to certify that I, the undersigned, consent to dental and oral surgery procedures as determined necessary or advisable, including the use of local anesthesia. I authorize the release of any records that are relevant to the processing and payment of this claim held by the service provider, any appropriate health professional licensing or regularity body for the purpose of administrative audit.

Name: _____ Signature _____ Date _____
Patient/Guardian as applicable Day/Month/Year