Dr. D. R. Jurasek Inc.

Office Phone: 250 833-1005
Home Phone: 250 804-9569
Email: Jurasek@shuswapdental.com

New Patient Form:

Please take the time to read and fill out this form to ensure your information is known prior to your appointment.

Patient Name: ______________________________________

If Patient is a Minor, Guardian's name: ____________________________________

Phone Number: ____________________

Gender: _____________________

Care Card: ________________________

Date of Birth: (Month/Day/Year): _________/____/______

Address: ____

E-mail: ________________________________

Primary Language: ______________________

Emergency Contact

Name: _______________________

Relationship: __________________

Contact Number: _______________

Today's Date: (Month/Day/Year): _________/____/______

Please see Office Policies on Next Page

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OFFICE POLICIES

APPOINTMENTS

Once you have made an appointment, the time is reserved especially for you. If you are unable to keep an appointment, please let us know **at least 24 hours in advance**, so that another patient can use that time.

- A minimum $50.00 **fee can be avoided with at least 24 hours advanced notice** in the event you cannot keep your appointment.

FINANCIAL

- Payment in full is expected for services rendered at the time of the appointment unless previous financial arrangements have been made.
- Interest charges apply to accounts after 30 days.

DENTAL INSURANCE

If you have dental insurance, the particular plan that you have is a contract between yourself and the company providing benefits. As we are doing you a service if we bill your plan directly, please understand that many plans exist and all plans do not provide the same benefits. It is very important that you make yourself familiar with the benefits provided by your plan, as it is difficult for our office staff to be knowledgeable on all plans and their various limitations.

- **Any services which are unpaid by your insurance company within 8 weeks of treatment remain your financial responsibility.**

I, ____________________________ have read and understood these office policies.

With regard to dental insurance claims:

- I, ________________________ authorize this dental office to contact my insurance company on my behalf, with personal information regarding dental treatment.
- I, ________________________ authorize release, to my insuring company plan administrator, the information contained in claims submitted electronically.
- I, ________________________ hereby assign my benefits payable from claims submitted electronically to Dr. Doug Jurasek and authorize payment directly to him.

After completing this form online, please save it to your computer and upload it to our website www.drjurasek.com or print it out and bring it in at your next appointment.

Signature of patient/guardian: ____