West Kootenay Community TEETH Clinic Society
Dental Office Client information FORM

CONTACT Information:

Address _____City _____Postal code _____

Phone_____ _____ _____
Home Cell Work
Email: _____

Can do short notice appointment ____ How much notice is needed _____

Client information

Please provide names, birthdates & **P**ersonal **H**ealth **N**umber's (**PHN**) of all family members applying to attend the clinic.

Please put the letter **E** next to a client's name if they have dental pain or infection, and **D** if they need a denture and **M** if on medication. Please bring a list of the medications to your appointment.

__Client _____ _____ _____ male _ __/___/___ _____
(First) Initial) (Last) Female_ dd/mm/yy Birthdate Personal Health No.

__Spouse_____ _____ _____ male _ __/___/___ _____
(First) Initial) (Last) Female_ dd/mm/yy Personal Health No

Children:

__Oldest _____ _____ _____ male _ __/___/___ _____
(First) Initial) (Last) Female_ dd/mm/yy Personal Health No.

__Next _____ _____ _____ male _ __/___/___ _____
(First) Initial) (Last) Female_ dd/mm/yy Personal Health No

__Next _____ _____ _____ male _ __/___/___ _____
(First) Initial) (Last) Female_ dd/mm/yy Personal Health No

__Next _____ _____ _____ male _ __/___/___ _____
(First) Initial) (Last) Female_ dd/mm/yy Personal Health No

Verifier's name:_____ _____ ____/_____/_____
Print signature dd/ mm /yy

Please scan and email to teethclinicwk@gmail.com , **or fax to 250 352-2282**
If this is a denture case please let clients know they will go on a wait list

West Kootenay Community TEETH Clinic Society
FINANCIAL / RESIDENCY APPLICATION

NOTICE: The information provided will be held in strictest confidence and not shared, except as it may be necessary in regards to medical information, medical emergency, treatment and records.

This information has been freely provided and the notice understood as indicated by my signature.

Name _____ _____ _____ DOB _____
(First) (Initials) (Last) dd/mm/yy
Number of Dependants? _____ Phone No._____

Address _____City_____Postal code _____

Personal Health No.:_____ Email _____

Do you identify as aboriginal? yes_____ no_____

Residency:
Proof of 3 months in Kootenay Boundary: Yes __

Financial:
Do you receive any form of income support? yes___ no___

Is your family income less than $30,000? yes___ no___

(**For Verifier Only**)
Confirmed: yes___ no____

Verified: yes___ no___

Verified: yes___ no___

I declare the above information is correct and accurately reflects my financial situation. I am aware this is not a free service and I am responsible for dental services costs.

Date___/____/_____ Signature of applicant_____
dd/ mm /yy

(for verifier only): List the types of proof submitted:_____

_____, _____ _____
print verifier's name **verifier's signature** **Date**

see pamphlet for verification locations
Email: verified forms to, teethclinicwk@gmail.com ,
or fax to 250 352-2282