



West Kootenay Community TEETH Clinic Society Dental Office Client information FORM

CONTACT Information:

Address _____ Postal code _____

Phone _____
Home Cell Work

Email: _____

Can do short notice appointment ____ If lives more than 15 minutes from Nelson where: _____

Client information

Please provide names, birthdates & **Personal Health Number'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 only.

__ 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 fax to 250 352-2282 or scan and email to dr.osepchook@telus.net
Please identify if any client is experiencing pain or infection next to client's name**



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. All applications must be verified by an approved verifier (see pamphlet for locations)

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 Dependents? _____ Phone No. _____

Address _____ 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

To be approved in either of the above categories the various documents of proof must be provided.

(for verifier only) **above types of proof submitted:** _____

print verifier's name

verifier's signature

Applications can be verified at the Senior Coordinating Society, 719 Vernon St.
Nelson V1L 4G3 **Mondays 10 am to 11:30** (see pamphlet for other locations)
Email verified forms to sencoord@netidea.com, or fax to 250 352-6008