DAVID L. TOBIAS INC. B.Sc., D.M.D., M.Sc.
GEORGE BONEV INC. D.M.D.
1705 – 805 West Broadway
Vancouver, B.C., V5Z 1K1

Dr./Mr./Mrs./Miss/Ms. (please circle one)

Last Name: _____

First Name: _____

Phone: H-_____ **W-** _____ **cell-**_____

Address: _____ **E-Mail**: _____

City: _____**Postal Code:** _____ Employer: _____

Birth: Month_____ Day_____ Year _____ Occupation: _____

Medical Dr. _____ Phone _____ If child, parent's name _____

Whom may we thank for referring you to our office? _____

With regard to your visit today, what is your primary concern? _____

Are you covered by a Dental Insurance Plan? Yes ☐ No ☐

If this is your partner's/parent's plan, please give her/his Name: _____

and Date of Birth: Month_____ Day_____ Yr_____

Many dental insurance plans allow us to submit claims electronically on your behalf. In order to do this we require your authorization.

I authorize the release of information contained in claims submitted electronically to my dental benefits provider. I also authorize the communication of information related to dental coverage and benefits to Dr. David Tobias Inc. and his employees by my dental insurance provider.

If allowed, I assign my benefits payable from claims submitted electronically to Dr. David L. Tobias Inc. and authorize payment directly to him.

This authorization shall continue in effect until the undersigned revokes the same.

_____ _____
Signature of patient, parent or guardian Date

PLAN 1
Name of Insured:_____
Insurance Co: _____
Group # _____ Div _____
ID # _____ Dep # _____
Basic _____ Endo/Perio _____ Major _____ Ortho ____
Maximum _____ Deductible _____
R/C limit _____ SC/RP limit _____

PLAN 2
Name of Insured: _____
Insurance Co: _____
Group # _____ Div _____
ID # _____ Dep # _____
Basic _____ End/Per _____ Maj _____ Ortho _____
Maximum _____ Ded _____
R/C limit _____ SC/RP limit _____