



# Children and Adult Dental Plan

Patient's Name: \_\_\_\_\_

Your provincially funded **Children and Adult Dental Plans** provide coverage for eligible services. To help in financially supporting this program we require that you fill out this simple form.

Do you have individual or family insurance coverage outside the Provincial Dental Health plan?

YES

NO

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_