EAST KILDONAN
DENTAL

807 Henderson Hwy, Winnipeg, MB R2K 2K9
204-661-2614

Patient Registration

First Name:_____ Last Name: _____ Middle Initial: _____ Pref. Name: _____
☐ Mrs.☐ Miss☐ Mr.☐ Dr.☐ Ms.

Information

Mailing Address: _____ Email: _____ (preferred)
City / Province: _____ Postal Code: _____
Home Ph: _____ Work Ph: _____ Ext: _____ Cell: _____
Sex: ☐ Male ☐ Female
Birth Date: _____ Age: _____
mm / dd / yyyy
Referred By: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Mailing Address: _____
City / Province: _____ Postal Code: _____
Home Ph: _____ Work Ph: _____ Ext: _____ Cell: _____
Birth Date: _____
mm / dd / yyyy
Emergency Contact: _____

Primary Insurance Information

Name of the Insured: _____ Birth Date of Insured: _____
mm / dd / yyyy
Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Common Law Spouse ☐ Other _____
Employer: _____ Plan/Group #: _____ Ins. Co.ID #: _____
Student: ☐ Yes ☐ No If yes; ☐ Full-time ☐ Part-time
Name of School: _____ Student ID #: _____

Secondary Insurance Information

Name of the Insured: _____ Birth Date of Insured: _____
mm / dd / yyyy
Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Common Law Spouse ☐ Other _____
Employer: _____ Plan/Group #: _____ Ins. Co.ID #: _____
Student: ☐ Yes ☐ No If yes; ☐ Full-time ☐ Part-time
Name of School: _____ Student ID #: _____

Medical and Dental History

- Occupation: _____
- Name / Location of your physician: _____
- Are you currently under treatment by a health care practitioner please specify: _____
- Are you taking any blood thinning medications? (Aspirin /ASA, Coumadin, Warfarin, Plavix, Heparin): _____
- Other Medications?: _____
- Do you have instructions from your doctor to take pre-medication for dental work? ☐ Yes ☐ No
  If yes, what? _____
- Have you ever been treated or diagnosed with any of the following conditions:

☐ Heart Attack: _____ ☐ Stroke: _____ ☐ High/Low Blood Pressure: _____
☐ Pacemaker _____ ☐ Valve Replacement _____ ☐ Other Heart Condition: _____
☐ HIV / AIDS: _____ ☐ Diabetes: _____ ☐ Hepatitis/Liver Disease _____
☐ Cancer: _____ ☐ Asthma/Hay Fever _____ ☐ Epilepsy/Fainting/Seizures _____
☐ Bleeding Problems: _____ ☐ Gonorrhea: _____ ☐ Headaches/Migraines: _____
☐ Candidiasis: _____ ☐ Syphilis: _____ ☐ Mono: _____
☐ Herpes: _____

☐ Allergies: ☐ Penicillin ☐ Codeine ☐ Latex ☐ Aspirin ☐ Local Anaesthetics ☐ Other _____

- Do you smoke? ☐ Yes ☐ No ☐ Quit How long have you been smoking/smoked? _____
- Are you or might you be pregnant? ☐ Yes ☐ No If yes, due date: _____ Are you nursing: _____
- IS THERE ANYTHING REGARDING YOUR HEALTH THAT WAS NOT MENTIONED THAT WOULD BE IMPORTANT FOR US TO KNOW BEFORE WE BEGIN? _____

Dental History: Previous Dentist: _____

- Why did you leave your previous dentist? _____
- Last time you have seen a dentist for exam or treatment: _____
- Last time you have had cleaning treatment for your gums & teeth: _____
- How often do you normally see a dentist: _____

Privacy Consent: Personal information is kept private by our dentists and staff. Information would be released for due diligence purposes. Payment is required at the time service is rendered. We are happy to provide you with an estimate. You may pay your account with VISA, Master Card, AMEX, debit or cash. I authorize the dental personnel to perform services for prevention and treatment of dental disease using the procedures and medications required and assume responsibility for the fees associated with those procedures.

Signature of patient, parent, or guardian: _____ Date: _____

PATIENT RESPONSIBILITIES

IF YOU HAVE DENTAL INSURANCE

The particular plan which you have is a contract between yourself and the company providing the benefits. We will try to advise you as to what services are covered under your plan and approximately how much you can expect to receive from the insuring company. Please bring in your contract or brochure so that we may discuss it with you.

As the patient, you authorize the treatment and are solely responsible for payment of the fees. We will, however, gladly submit any insurance claims for the treatment done as as well as any pre-determinations that you require to your insurance company on your behalf.

You may pay your account yourself and be reimbursed by your plan, or we will accept assignment of your dental plan on the following basis only:

a. At the time of treatment, you pay the percentage which the plan does not pay. (i.e. If you are covered 80%, you will be responsible for the 20% as services are rendered.)
b. If the payment is not received from your plan within the customary thirty days, we will notify you for payment. We will then re-submit the claim directing payment to you. (For dual insurance we will allow up to sixty days.)
c. If there is a balance owing on your account after receipt of the insurance cheque(s), we will send you a statement indicating the balance.

PRIVACY POLICY

In accordance with the Privacy Act and PHIA (Personal Health Information Act), East Kildonan Dental Group requires all dentists & employees to handle sensitive personal client information in a confidential and appropriate manner.

Patient information is collected on our private server and kept indefinitely.

This information may be disclosed to third parties for investigation purposes (ex. insurance companies) and other health care providers for delivery of dental care.

Patients can retrieve a copy of their files by written request.

MISSED APPOINTMENTS

Your appointments are reserved especially for you. We understand that your time is important to you and we hope you appreciate that it is also important to us. Being on time and keeping your appointments helps us maintain our schedule so that no one's time is wasted.

- **If you are unable to keep a scheduled appointment, at least 24 hours notice must be provided. Failure to do so may result in a minimum $70.00 charge for a missed appointment.**
- **More than one missed appointment, may cause us to consider dismissal and requesting you to seek the services of another dental office.**

Thank you for your commitment and understanding.

I have read and agree to comply to the above conditions.

Signature of patient, parent, or guardian: _____ Date: _____