EAST KILDONAN
DENTAL

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

Patient Information

□ Mr. □ Mrs. □ Ms. □ Miss □ Mstr. □ Dr.

Name: ____Middle Initial: ______ Pref. Name: _______________
First Last

Mailing Address: _______________________________City: ___________________ Province: _______ Postal Code:__________

Home Ph: _______________________ Cell Ph: ________________________Work Ph: ______________________Ext:_________

Birth Date: _____________________________ Age: ___________ Email: ____
mm/dd/yyyy

Gender as on Health Card : □ Male □ Female Occupation: ______________________________________

Preferred Contact Method: □ Home Phone □ Cell Phone □ Work Phone □ Email □ Mail

Referred By: □ Word of Mouth □ Live Nearby □ Online □ Staff Referral □ Professional Referral

□ Marketing □ Other **(Please specify) ___________________________________**

Guardian/Responsible Party: Name:_______________________________Phone Number: _____________________________

Emergency Contact: Name: ______________________________________ Phone Number: _____________________________

Insurance Information

Primary Insurance Company: __________________________ Subscriber Name: ____________________________________

Subscriber Birth Date: _________________________________ Relationship to Subscriber: □ Self □ Spouse □ Child □ Other
mm/dd/yyyy

Subscriber ID #: ______________________________________ Plan/Group #: ____

Employer: ____

Is the patient a student? If yes, □ Full Time □ Part Time Name of school: _______________________________________

Secondary Insurance Company: __________________________ Subscriber Name: __________________________________

Subscriber Birth Date: __________________________________ Relationship to Subscriber: □ Self □ Spouse □ Child □ Other
mm/dd/yyyy

Subscriber ID #: ____Plan/Group #: _______________________________________

Employer: ____

Is the patient a student? If yes, □ Full Time □ Part Time Name of school: _______________________________________

Dental History

What is your most immediate dental concern? ____

Previous dentist: __________________________ Why did you leave your previous dentist? ____________________________

Date (Month/Year) of your most recent: Dental Cleaning _____ /_____ Exam and Xrays _____ /_____

On average I see my dentist every: ◻ 3 Months ◻ 4 Months ◻ 6 Months ◻ 12 Months ◻ Not Routinely

Medical History

Name of your physician: ______________________________ Name of Clinic: ____

Are you currently under the care of an Osteopath, Homeopath or any other Health Care Practitioner? _____________________

Are you currently taking any medications, prescriptions, supplements or herbs? (Please list all): __________________________

____

Are you taking any blood thinning medications? (Aspirin/ASA, Coumadin, Warfarin, Plavix, Heparin etc.): ________________________

For Females only: Are you or might you be pregnant? If yes, due date: ___________________ Are you nursing: ◻ Yes ◻ No

Have you ever had any major surgeries? If so what type: ____

Has your doctor instructed you to take pre-medication prior to dental treatment? (If yes, please specify) ______________________

Have you ever taken medication for osteoporosis? (Bisphosphonates)____

Do you smoke? How many years have you smoked for? ____ ◻ Yes ◻ No ◻ Quit

Are you allergic to any of the following: ◻ Latex ◻ Codeine ◻ Penicillin/Amoxicillin ◻ Aspirin ◻ Local Anaesthetics ◻ Tylenol

Please list any other allergies: ____

Have you ever been treated or diagnosed with any of the following conditions?

- ◻ Bleeding Disorders: ___________________________
- ◻ High/Low Blood Pressure (CIRCLE ONE): _______________
- ◻ Heart Attack: ________________________________
- ◻ Stroke: ____________________________________
- ◻ Pace Maker: _______________________________
- ◻ Other heart condition: _______________________
- ◻ Valve Replacement: __________________________
- ◻ HIV/ AIDS: _________________________________
- ◻ Candidiasis: ________________________________
- ◻ Gonorrhea: ________________________________
- ◻ Syphilis: ___________________________________
- ◻ Hepatitis: __________________________________
- ◻ Cancer: ____________________________________
- ◻ Diabetes: ___________________________________
- ◻ Asthma/Hay Fever (CIRCLE ONE): ____________________
- ◻ Liver Disease: _______________________________
- ◻ Headaches/Migraines (CIRCLE ONE): __________________
- ◻ Epilepsy/Fainting/Seizures (CIRCLE ONE): ______________
- ◻ Mono: _____________________________________
- ◻ Osteoporosis: _______________________________
- ◻ Artificial Joints: _____________________________
- ◻ Kidney Disease: _____________________________
- ◻ Pulmonary Embolism: _________________________
- ◻ Other: _____________________________________

Is there anything else regarding your health that would be important for us to know? ______________________________

Personal Information is kept private by our dentists and staff. Information would be released for due diligence purposes. I certify that I have read and completed the personal, dental and medical histories to the best of my ability. I authorize the dental personnel to perform services for prevention and treatment of dental disease using the procedures and medications required. I assume responsibility for the fees associated with those procedures.

Signature of patient, parent or guardian: ____ Date: ___________________________

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Office Policies

Dental Insurance

The particular plan which you have is a contract between yourself and the company providing 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 and what your portion will be. Please bring in your insurance breakdown booklet 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 gladly submit any insurance claims for the treatment done 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;

1. At the time of treatment, you pay the percentage which the plan does not pay. (i.e., If you are covered at 80%, you will be responsible for the 20% as services are rendered.)
2. If the payment is not received from your insurance company within the customary thirty days, we will notify you for payment. We will then resubmit the claim directing payment to you. (For dual insurance, we will allow up to sixty days.)
3. If there is a balance owing on your account after receipt of the insurance payment, we will send you a statement indicating the balance. **This balance must be taken care of immediately upon notification of the statement.**

Payment Options

For your convenience we accept the following forms of payment:

Interac, Mastercard, Visa, American Express, Cash, Personal Cheques and E-transfer

Privacy Policy

In accordance with the privacy act and PHIA (Personal Health Information Act), East Kildonan Dental Group requires all dentists and 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 ones 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.
- More than one missed appointment may cause us to consider dismissal and request you seek the service 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: ____________________________

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COVID-19 Pandemic Emergency Dental Treatment Consent Form

Please read and Initial in all the indicated spots.

Patient name: ____

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that dental procedures create water spray which is one way that the novel coronavirus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. ___________ (Initial)

I confirm that I **am not** presenting any of the following symptoms of COVID-19 identified by Manitoba Health Services:

- Fever > 38°C ___________ (Initial)
- Cough ___________ (Initial)
- Sore Throat ___________ (Initial)
- Shortness of Breath ___________ (Initial)
- Difficulty Breathing ___________ (Initial)
- Flu-like symptoms ___________ (Initial)
- Runny Nose ___________ (Initial)

I confirm that I am not in a high-risk category, including: diabetes, cardiovascular disease, hypertension, lung diseases including moderate to severe asthma, being immunocompromised, having active malignancy, or over age 65. ___________ (Initial) **OR** I fall into the following high-risk category (__________________) and my dentist and I have discussed the risks, and I agree to proceed with treatment. ___________ (Initial)

I confirm that I am not currently positive for the novel coronavirus. ___________ (Initial)
I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus. ___________ (Initial)

I verify that I have not returned to Manitoba from any country outside of Canada whether by car, air, bus or train in the past 14 days. ___________ (Initial)

I understand that Manitoba Health Services has asked individuals to maintain physical distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive dental treatment. ___________ (Initial)

I verify that I have not been identified as a contact of someone who has tested positive for novel coronavirus or been asked to self-isolate by Manitoba Health, the Communicable Disease Control or any other governmental health agency. __________ (Initial)

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

Signature of patient, parent or guardian: ________________________________ Date: ____________________________