PINE RIDGE DENTAL

Dr. Brian Maddaford 1-30 Co-op Drive Oakbank, MB R0E 1J0 204-444-4430 Dr. Christine Kveder

Patient information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____ Date of Birth: _____ (D/M/Y)

Phone (Home): _____ (Cell): _____ (Work): _____

Best time to call: _____ Where? Home ☐ Cell ☐ Work ☐

Patient Employment: _____ Occupation: _____

Home Address: _____
(Civic) Street City/Town Postal Code

Mailing Address: _____
(if different from Above)

E-mail: _____

How did you hear about our office? ☐ Sign ☐ Yellow Pages ☐ Newspaper ☐ Website ☐ Friend ☐ Patient ☐ Other
Name of person or office referring you to our practice: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies _____
_____
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Hard to Freeze
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Acid Reflux
☐ Pre-Medication
OTHER:
_____
_____
_____

. Have you ever had any complications following dental treatment? Yes ☐ No ☐

If yes, please explain: _____

. Have you been admitted to a hospital or needed emergency care during the past two years? Yes ☐ No ☐

If yes, please explain: _____

. Are you now under the care of a physician? Yes ☐ No ☐

If yes, please explain: _____

. Name of Physician: _____ Phone: _____

. Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Insurance Information/Person Responsible for Account

Person Responsible for account: _____ Relationship to Patient _____

Primary

Insurance Plan Name: _____

Name of Insured: _____ Is insured a patient? Yes ☐ No ☐
Last First MI

Insured's Birth Date: _____ (D/M/Y) Group/Plan #:_____ ID/Cert#: _____

Insurance Annual Max: _____ Percentage of Coverage: Basic _____ % Major _____ %

Patient's relationship to insured: Self ☐ Spouse ☐ Child ☐ Other_____

Secondary

Insurance Plan Name: _____

Name of Insured: _____ Is insured a patient? Yes ☐ No ☐
Last First MI

Insured's Birth Date: _____ (D/M/Y) Group/Plan #:_____ ID/Cert#: _____

Insurance Annual Max: _____ Percentage of Coverage: Basic _____ % Major _____ %

Patient's relationship to insured: Self ☐ Spouse ☐ Child ☐ Other_____

Consent for Services

I consent to the performing of dental and/or oral surgery procedures, including the use of local anesthetic and other medications when required.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare & submit the patient's insurance forms or assist in making collections from insurance companies to the Patient. However, this dental office cannot render services on the assumption that it will be paid by an insurance company.

In consideration for the professional services rendered to me by this practice, I agree to pay the full charges for the services at the time of treatment.
I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read the above agree to their content.

_____ Date: _____ Relationship to Patient:

Signature of patient, parent or guardian