Winona DENTAL

NEW PATIENT FORM

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: DD / MM / YY Gender: M: ☐ F: ☐ Referred By: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Phone: _____ Secondary Phone: _____ Email: _____

Employer: _____ Occupation: _____

EMERGENCY/MEDICAL INFORMATION

Form of ID: *[Driver's License, Passport, Birth Certificate etc.]* _____

Number: _____ Expiration Date: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Physician: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Area of Specialty: _____

FINANCIAL INFORMATION/PERSON RESPONSIBLE FOR ACCOUNT

Complete the following if information is different from above.

First Name: _____ Last Name: _____

Date of Birth: DD / MM / YY Gender: M: ☐ F: ☐ Phone: _____ Alt.: _____

1262 HIGHWAY 8 WINONA, ON L8E 5K3 289.656.0599 INFO@WINONADENTAL.COM

Address:

City/Town: Province: Postal Code:

PRIMARY INSURANCE

Suscriber First Name: Suscriber Last Name:

Date of Birth: Insurance Company: Employer/Policy Holder:

DD / MM / YY

Policy Number: Certificate/ID: Div:

SECONDARY INSURANCE

Suscriber First Name: Suscriber Last Name:

Date of Birth: Insurance Company: Employer/Policy Holder:

DD / MM / YY

Policy Number: Certificate/ID: Div:

OFFICE POLICY

I understand that when appointments are scheduled, staff and facilities are reserved for me, and that at least two (2) business days notice is required for any changes to my appointment, or a fee may be applied to my account. I agree to pay for services at each visit as they are performed unless other prior arrangements have been made. Please indicate one of the following with a check mark:

- ☐ I wish to pay each visit as the services are performed.
- ☐ I wish to know the total fee for all work to be done, as well as the number of appointments and pay equal portions at each appointment.
- ☐ I wish to discuss special arrangements for payment.

Please note that valid identification is required for all cheque payment and there is a minimum $50 service charge for any returned payment items, e.g., cheques.

CONSENT

I certify that I have provided accurate and complete personal information and have not knowingly omitted any information. I had the opportunity to ask questions and receive answers to any questions regarding my medical and dental history. I authorize Winona Dental, the registered business name of Dr. Samantha Wong Dentistry Professional Corporation, Dr. Wong and the staff to perform diagnostic procedures and treatment that may be necessary for proper dental care. I consent to my physician or specialist being contacted, if necessary, for information that may be required for my dental care. I consent to the performing of dental procedures which have been discussed with me and agreed to be necessary or advisable.

I understand that the fees are in accordance with the current Ontario Dental Association suggested fee guide, and I assume all responsibilities for any fees associated with the dental services provided by Dr. Wong and staff. I authorize my insurance claims to be submitted electronically where applicable, and understand that full payment is required at the time of service, unless prior arrangements have been approved.

I authorize release to my dental benefits plan administrator and the Canadian Dental Association, information contained in claims submitted electronically. I also authorize the communication of information related to coverage of services described in my claim forms to Dr. Wong.

Signature of Parent/Patient/Guardian: Parent/Guardian Name: Date:

Privacy Policy: All information contained in this form is confidential. We are fully compliant with Ontario and Canadian Privacy Laws.