KILDARE
DENTAL CENTRE

6 - 630 Kildare Avenue East
Winnipeg, MB R2C 0P8
204.222.7252 info@kildaredental.ca

Patient Information

First Name _____ Last Name _____

Street Address _____

City _____ Province _____ Postal Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Preferred Contact Method: ○ Home Phone ○ Work Phone ○ Cell Phone ○ Email

Date of Birth (day / month / year) _____ Driver's License _____

EMERGENCY CONTACT

Name _____ Phone _____

Relationship to Patient _____

PAYMENT INFORMATION

Who is responsible for payment of your account? _____

Relationship to Patient _____ Phone _____

Place of Employment _____

Do you have dental insurance? ○ Yes ○ No

DENTAL INSURANCE (PRIMARY)

Employee Name _____ Employee # _____

Insurance Company _____ Group/Policy # _____

Employer _____ Contract/Div. # _____

DENTAL INSURANCE (SECONDARY)

Employee Name _____ Employee # _____

Insurance Company _____ Group/Policy # _____

Employer _____ Contract/Div. # _____

CONSENT FOR DENTAL TREATMENT AND DENTAL FEE POLICY

I consent to allowing Dr. Sas, his staff and associates to perform diagnostic and dental treatment as may be necessary for proper dental care. I am aware of any reasonable alternatives and complications of the proposed dental treatment. I understand that Dr. Rahul Sas Dental Corporation and the Kildare Dental Centre charge fees for dental procedures in accordance with the current year fee guide set forth by the Manitoba Dental Association. I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance may or may not pay for the entire cost of dental treatment and that I am ultimately financially responsible for the entire cost of mine and my dependents dental treatment. I also understand that if my account is in arrears I will be charged interest at a rate of 1.5%/month (18%/year) until such account is paid in full.

Signature of Patient/Guardian _____ Date _____