Winkler Dental Clinic
Samantha Klassen Dental Corp
Box 1689 / 500 Main St. N
Winkler MB R6W4B5
(204)325-4343
winklerdentalclinic@gmail.com
www.WinklerDentalClinic.com

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #.

FOR OFFICE USE ONLY

Patient Name:

Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc

Gender: ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: Prev. Visit: Email Address:

Phone: Home Work Ext Mobile

Best time to call:

Address:

City PV Postal Code

Parent/Guardian Name:

Preferred appointment times:

- ☐ Mon
- ☐ Tue
- ☐ Wed
- ☐ Thur
- ☐ Fri
- ☐ Morning
- ☐ Afternoon
- ☐ Any time

Name of person, office, or other source referring you to our practice:

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Consent for Services

Any balance on the account for services rendered will be the responsibility of the undersigned regardless of insurance involvement. I will pay my balance on the day of treatment. Any discrepancy between what is understood that insurance would pay and what they actually pay automatically becomes my responsibility.

By signing below I assign my dental benefits (if applicable) for dental claims submitted electronically by Winkler Dental Clinic and authorize payment directly to the Winkler Dental Clinic. This authorization shall continue in effect until the undersigned revoked the same.

The Winkler Dental Clinic requires 24 hours notice for any appointment changes or cancellations. We reserve the right to charge a fee of $72.00 in the event that this policy is not adhered to. The fee must be paid before any appointment will be rescheduled for yourself or any family member.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: ______________________________ Date: __________

Relationship to Patient:

____

Response Date: __________