On-Site Oral Health Program Registration Form

Patient's Name: ____ Date of Birth: __________________
(M/D/Y)

Patient Address (PCH): ____

City: ______________________ Province: _______ Postal code: ______________ Floor: ____ Room: ______

Person responsible for account or Legally Acceptable Representative (LAR):______________________________

Address of LAR: ____City: __________________

Province: _________ Postal code: ____________ Home Phone: ______________ Work:_________________

Reason for Appointment: ____

If patient is covered under Public/Government Dental Insurance bill to: (Select One)

☐ Non Insured Health Benefits (First Nations & Inuit Health Branch) Treaty #: _____________________

☐ Employment and Income Assistance (Social Assistance) health certificate #: _____________________

☐ Department of Veteran Affairs (DVA) ID Number: K___________________

☐ For Private Dental Insurance – Payment of exam fee is required before treatment.
Reimbursement for payment is made directly from insurance company to patient: (please include)

Insurance Company: ______________________ Group #: _________________ ID #: ______________

For ALL other Patients: PAYMENT is required BEFORE TREATMENT

PAYMENT of EXAM Fee $120.00 Payable by:
☐ Cheque (Enclosed)
☐ Credit Card - Visa/MC (please call)

RETURN FORM TO:

Dental Access Manitoba
616 Maryland Street
Winnipeg, Manitoba R3E 1V9
P: (204) 336-8873 or (204) DEN-TURE
F: (204) 775-3030

Upon the receipt of this form Dental Access Manitoba will schedule an appointment for exam. After examination, a written treatment plan and cost estimate will be sent to the person responsible for the account. Signed consent of the treatment plan will be required for all subsequent treatment.

Signature (LAR) X____ Date: ____________________

The personal information being collected under the authority of **Dental Access Manitoba** will be used for the provision of dental services. It is protected by the Protection of Privacy Provisions of **The Freedom of Information and Protection of Privacy Act**.