ClearCare
Periodontal & Implant Centre

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PATIENT REGISTRATION FORM

Today's Date:	Manitoba Health # (PHIN):		
Patient's last name:	First:	Middle:	Title:
Gender:	Date of Birth (MM/DD/YY):	Age:	Marital status:
Address:			
Street	City	Province	Postal Code
Home phone #:	Cell phone #:	Work phone #:	
Occupation:	Employer:	Employer phone #:	
Email address:			
Who may we thank for this referral?			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Dental Insurance Provider:		
Name of Insured:	Address (if different):	
Date of Birth (MM/DD/YY):	Occupation:	Employer:
Group/Policy #:	Division #:	ID #:
Certificate #:	Work phone #:	
Secondary Dental Insurance Provider:		
Name of Insured:	Address (if different):	
Date of Birth (MM/DD/YY):	Occupation:	Employer:
Group/Policy #:	Division #:	ID #:
Certificate #:	Work phone #:	
Patients relationship to subscriber:		

IN CASE OF EMERGENCY

Name:	Relationship:
Home Phone #:	Work Phone #:

I authorize the specialist to conduct a dental examination and perform treatment as deemed necessary for proper dental care.

I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done.

I understand that I am responsible for payments in full for all professional services at the time each service is performed. I understand that an estimate of treatment costs will be given to all new and recall patients and that actual cost for services maybe higher or lower. By signing this form, I revoke all previous agreements to the contrary and agree to be responsible for payment of service not paid in whole or in part by my dental care provider.

I authorize the communication and release of information concerning my (my child's) related treatment to other dentists or specialists.

I authorize the communication and release of information contained in my claim forms to my insurance provider/plan administrator.

APPOINTMENT POLICY: Our policy requires that if you wish to cancel and appointment, you must provide our office with a 48 hours notice. Appointment cancellations with less than a 48 hours notice are subject to charges.

I have read the above conditions and agree to their content.

_____ _____

Signature of Patient/Guardian | Date

DENTAL HISTORY

Please Check "Yes" or "No" to indicate if you have had any of the following

Bad Breath	❑ Yes ❑ No	Sores or growths in your mouth	❑ Yes ❑ No	Dry mouth	❑ Yes ❑ No
Bleeding gums	❑ Yes ❑ No	Blisters on lips or mouth	❑ Yes ❑ No	Mouth breathing	❑ Yes ❑ No
Gums swollen or tender	❑ Yes ❑ No	Burning sensation on tongue	❑ Yes ❑ No	Lip or cheek biting	❑ Yes ❑ No
Loose teeth	❑ Yes ❑ No	Grinding teeth/bruxism	❑ Yes ❑ No	Have you had your teeth bleached?	❑ Yes ❑ No
Food collection between teeth	❑ Yes ❑ No	Jaw pain or tiredness	❑ Yes ❑ No	Are you a smoker?	❑ Yes ❑ No
Sensitivity to hot or cold	❑ Yes ❑ No	Fingernail biting	❑ Yes ❑ No	How often do you smoke?	
Sensitivity to sweets	❑ Yes ❑ No	Chew ice cubes regularly	❑ Yes ❑ No	How often do you floss?	
Sensitivity when biting	❑ Yes ❑ No	Clicking or popping jaw	❑ Yes ❑ No	How often do you brush your teeth?	
Previous periodontal treatment	❑ Yes ❑ No	Orthodontic treatment	❑ Yes ❑ No	How often do you get cleaning?	

Have you had any serious trouble associated with any previous dental treatment? ❑ Yes ❑ No
If yes, please explain: _____

Do you bleed excessively after tooth extraction? ❑ Yes ❑ No

Do you have a bad taste in your mouth? ❑ Yes ❑ No

Have you had any undesirable reactions to local or general anesthetics? ❑ Yes ❑ No

Are you happy with the appearance of your teeth? ❑ Yes ❑ No

Have you had excessive pain or swelling after oral surgery? ❑ Yes ❑ No

Are you willing to become actively involved in the treatment of your periodontal disease? ❑ Yes ❑ No

What is your chief complaint concerning your mouth or teeth? _____

MEDICAL HISTORY

Are you taking any medications at this time? ❑ Yes ❑ No
If yes, what type? _____

Dare you sensitive or allergic to any medication? ❑ Yes ❑ No
If yes, what type? _____

For Women: Are you taking birth control pills? ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No

HIV/AIDS	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Anemia	❑ Yes ❑ No
Cancer/Chemotherapy	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Epilepsy or Seizures	❑ Yes ❑ No	Arthritis	❑ Yes ❑ No
Tuberculosis	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No	Psychiatric treatment	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No
Scarlett Fever	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Bladder Disease	❑ Yes ❑ No
Heart Murmur	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Nervousness	❑ Yes ❑ No
Thyroid Disease	❑ Yes ❑ No	Stroke	❑ Yes ❑ No	Fainting or Dizzy Spells	❑ Yes ❑ No

Do you have pain in the chest upon exertion? ❑ Yes ❑ No

Do you have shortness of breath? ❑ Yes ❑ No

Do you bruise easily? ❑ Yes ❑ No

Have you ever had Yellow Jaundice? ❑ Yes ❑ No

Are you thirsty much of the time? ❑ Yes ❑ No

Have you lost or gained weight (more than 10 pounds) in the last year? ❑ Yes ❑ No

Are you following a diet? ❑ Yes ❑ No

Has a doctor ever said you have cancer or a tumor?	❑ Yes ❑ No
Have you ever had excessive bleeding from a cut or wound?	❑ Yes ❑ No
Do you have frequent severe headaches?	❑ Yes ❑ No
Do you sometimes take medicine to relieve nervousness?	❑ Yes ❑ No
Do you have any disease, condition, or problem not listed above? If yes, please explain _____	❑ Yes ❑ No

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE ANSWERS ARE TRUE AND CORRECT. IF I HAVE ANY CHANGE IN MY HEALTH, I WILL INFORM_____ AT MY NEXT APPOINTMENT.

_____ _____

Signature of Patient/Guardian Date

Comments: