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ClearCare Periodontal & Implant Centre

PATIENT REGISTRATION FORM

Today's Date:	Preferred Pronoun:	Manitoba Health # (Register and PHIN):		
Patient's last name:		First:	Preferred:	Date of Birth (MM/DD/YY):
Address:				
City:	Province:	Postal Code:		
Home phone #:		Cell phone #:		Work phone #:
Email:	**Preferred Contact:**	**Email ❑**	**Cell Phone ❑**	**Text Messaging ❑** **Home Phone ❑**
Family Physician:	Address:		Phone Number:	
Preferred Pharmacy:	Address:		Phone Number:	

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):	
Group/Policy #:	Certificate/ID:
Secondary Dental Insurance Provider:	
Name of Insured:	
Date of Birth (MM/DD/YY):	Address (if different):
Group/Policy #:	Certificate/ID:
Patient's 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 may be 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 an appointment, you must provide our office with 48 hours notice. Appointment cancellations with less than a 48 hours' notice are subject to charges.

I have read the above conditions and agree with 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 cleanings?	

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 currently taking any medications? ❑ Yes ❑ No
If yes, what type? _____

Do you require premedication before dental treatment? ❑ Yes ❑ No

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

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 (Herpes)	❑ 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
Are you taking birth control pills?	❑ Yes ❑ No
Are you pregnant?	❑ 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.

I _____, GRANT **CLEARCARE PERIODONTAL & IMPLANT CENTRE** PERMISSION TO TAKE PHOTOGRAPHS AND/OR VIDEOS OF MY JAW AND TEETH (FULL-FACE SHOTS WILL NOT BE USED) FOR MAINTAINING RECORDS FOR RESEARCH, EDUCATION (LECTURES AND SEMINARS) AND MARKETING MATERIAL (WEBSITES, SOCIAL MEDIA, PRINTED MATERIALS, PATIENT EDUCATION). I UNDERSTAND MY NAME WILL BE KEPT CONFIDENTIAL. IF MY PHOTOGRAPHS AND/OR VIDEOS ARE USED THEY WILL NOT CONTAIN ANY IDENTIFIABLE INFORMATION.

IMAGES WILL BE STORED IN A SECURED LOCATION AND ONLY AUTHORIZED STAFF WILL HAVE ACCESS TO THEM. THEY WILL BE KEPT AS LONG AS THEY ARE RELEVANT AND AFTER THAT TIME DESTROYED OR ARCHIVED.

_____ _____

Signature of Patient/Guardian Date

Comments: