

## Patient Registration Form

Date of Visit: \_\_\_\_\_ Salutation: Mr. Mrs. Ms. Miss/Master  
 First Name \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Gender: Male Female  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home Tel: \_\_\_\_\_ Work: \_\_\_\_\_ ext. \_\_\_\_\_ Cell: \_\_\_\_\_  
 E-mail address: \_\_\_\_\_  
 Best Time To Contact You: Morning Afternoon Evening Best Method: E-mail Home # Cell #

### Emergency Contact: In case of an emergency, who should we call?

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
 Home Tel #: \_\_\_\_\_ Work Tel #: \_\_\_\_\_ Cell #: \_\_\_\_\_

### Financial Responsibility: I am over 18 years old and responsible for my account. I am under 18 years old and the following person is responsible for my account:

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Tel Home: \_\_\_\_\_ Work \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

### Medical History: Have you ever had any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> AIDS/ HIV   | <input type="checkbox"/> Head Injuries   | <input type="checkbox"/> Radiation Treatment                       |
| <input type="checkbox"/> Allergic to: _____  | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Respiratory Problems                      |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Heart Murmur  | <input type="checkbox"/> Sinus Problems                            |
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Smoking                                   |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Migraines   | <input type="checkbox"/> Stomach problems                          |
| <input type="checkbox"/> Blood Disorder: _____   | <input type="checkbox"/> Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low | <input type="checkbox"/> Stroke                                    |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Jaundice  | <input type="checkbox"/> Thyroid Disorder                          |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II | <input type="checkbox"/> Kidney Disorder   | <input type="checkbox"/> Tuberculosis                              |
| <input type="checkbox"/> Dizziness   | <input type="checkbox"/> Liver Disorder  | <input type="checkbox"/> Ulcers                                    |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Nervous System Disorder   | <b>For Women:</b> Are you currently                                |
| <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Mental Disorder   | Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Fainting  | <input type="checkbox"/> Pacemaker   | Due Date: _____  |
| <input type="checkbox"/> Glaucoma  |  |  |

Additional notes re: health: \_\_\_\_\_

Please list your regular medications: \_\_\_\_\_

Have you been hospitalized or required emergency medical care in the last two years?  No  Yes, provide details below

Name of your physician: \_\_\_\_\_ Tel #: \_\_\_\_\_

**Identification Required For Prescriptions:** New regulations require us to obtain photo ID in order to write many prescriptions. Please provide either your photo Health card or photo Driver's License to the reception. .

**ADMIN USE:** Photo ID Scanned to file?  Photo Health Card  Photo Driver's License Card  None

## Dental History & Concerns

Mark the areas that apply, and if desired, use the lines to provide additional details.

When was your last dental visit? \_\_\_\_\_ Name of dentist: \_\_\_\_\_

What did you like about your previous dental office? \_\_\_\_\_

Anything you disliked about your previous dental office? \_\_\_\_\_

Do you need sedation to make your visits comfortable? \_\_\_\_\_

Do your gums bleed at all when you brush your teeth? \_\_\_\_\_

Do you experience a bad taste or odour in your mouth? \_\_\_\_\_

Are any of your teeth sensitive to hot or cold? \_\_\_\_\_

Are any of your teeth sore to chew on? \_\_\_\_\_

Does your jaw click or crack or pop? \_\_\_\_\_

Do you want whiter teeth? \_\_\_\_\_

What are your goals for your visit today? \_\_\_\_\_

## Insurance Coverage

### Primary Insurance

Name Of Insured: \_\_\_\_\_

Male  Female Date Of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group/ Plan/ Policy #: \_\_\_\_\_

ID / Certificate #: \_\_\_\_\_

### Secondary Insurance

Name Of Insured: \_\_\_\_\_

Male  Female Date Of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group/ Plan/ Policy #: \_\_\_\_\_

ID / Certificate #: \_\_\_\_\_

## Who Can We Thank For Your Referral?

A friend or  family member named: \_\_\_\_\_

Google Search  Yellow Pages  Billboard/ In mall  SNAP Clarington  Clarington This Week

TV Commercial / Smile Canada Website  Other \_\_\_\_\_

*We will gladly accept your friends and family members in our practice. Feel free to share our contact information. Thank you!*

## Appointment Cancellations

I understand that when an appointment is booked for me, the time is reserved with my care provider and materials are set for me. If I need to change or cancel an appointment, I will provide 2 business days notice (unless a grave emergency occurs). I understand that without 2 business days notice, a \$60 charge may apply.

I initial to signify that I understand this policy: \_\_\_\_\_

**To the best of my knowledge, all the information I have provided herein is accurate and complete. I consent to a dental examination today. I consent to basic restorative care, as recommended by the examining dentist.**

\_\_\_\_\_  
Signature of Patient OR Guarantor Of Payments

\_\_\_\_\_  
Date:

## Insurance & Payment Agreement

Our mission at Platinum Dental is to provide excellence in dentistry that meets your individual needs.

As your dental health care providers, our job is to **assess your oral condition and advise you of** the health of your mouth or of any decay, infections, tissue damage, bone loss or other conditions you may have.

Just like any other doctor, we are obligated to treat all patients the same. **We advise you of treatment options based on your condition, regardless of whether or not you have insurance or what it may or may not cover.** Insurance plans are **not** designed to meet individual treatment needs. You can choose to proceed or decline treatment. If you have the benefit of some insurance coverage, it is **your responsibility to know what is and isn't covered.** We will gladly submit an estimate to your insurance for you.

**There are over 65,000 different plans in Ontario alone. We do not know what yours covers.**

Just like the grocery store, your auto service business, your hairdresser or barber etc, **payment is expected on the day of your appointment.** Please choose your preferred method of payment:

**Option #1 Payment in full on day of appointment. Benefit from insurance company paid directly to you**

Payment is made in full by cash, interact, Visa, or MasterCard by the patient or guardian for the patient. We will process your dental insurance claim for you. Any **insurance benefit payment owing is sent directly to you**, usually between 1-5 business days. Patients choose this method to avoid any balance from ever accruing on their account, and to keep their account simple and easy to understand.

**Option #2 Insurance pays Platinum Dental directly + patient or guardian pays their portion directly. To choose this option, a credit card is required, on file.**

We will accept payment directly from your insurance company if your insurance allows for it, and:

- Your portion is paid on the day of your visit (or as soon as your ins. company indicates what the portion is)
- A valid credit card is kept on file, to which your payment will be billed if you either 1) authorize it or 2) can't make it in to the office to make your payment within 30 days

To choose this option, provide a credit card number & sign below:

**I hereby agree** to assign payment of my dental benefits directly to Platinum Dental. I hereby authorize Platinum Dental to charge my credit card below, for any balance 31 days past due.

**CREDIT CARD NUMBER:** \_\_\_\_\_ **EXPIRY:** \_\_\_\_/\_\_\_\_

**NAME ON CARD:** \_\_\_\_\_ **CSV:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_