MCCABE DENTURE CLINIC & IMPLANT SOLUTIONS

PATIENT REGISTRATION FORM

(Please Print Clearly. Please email your completed form to info@clinicdenture.com before your appointment, or print a copy and bring it with you.)

Today's date:

PATIENT INFORMATION

Last name:	First Name:		Middle:	
Birth Date (MM/DD/YYYY):	Age:	Sex: ❑ M ❑ F	Street Address:	P.O. Box:
City:	Postal Code:	Home Phone No.:	Cell Phone No.:	
Email Address:		Family Doctor:	Dentist:	
Reason for your visit:				

Chose clinic because/Referred to by ❑Dr. _____ ❑ Newspaper ❑ Yellow Pages ❑ Online

❑ Medical Centre/Life Labs ❑ Close to home/work ❑ Family/Friend ❑Other _____

POWER OF ATTORNEY (IF APPLICABLE)

Last Name:	First Name:	Phone Number:
Mailing Address:		

We will be happy to provide you with the information necessary to file with your insurance company for reimbursement. However, we do not accept assignment of benefits. To file a claim properly, we ask you to provide complete insurance information. Patients assume ultimate responsibility of their case. Therefore, appropriate payment is expected and appreciated at time of service.

Do you have insurance? ❑ Yes ❑ No ❑ ODSP/OW (If checked, please leave remaining insurance information blank and give card to receptionist)			
Primary Insurance Co.	Employer:		
Name of Policy Holder:	Birth Date (MM/DD/YYYY):	Group no.:	Policy/certificate no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Secondary Insurance Co. (if applicable)			
Name of Policy Holder:	Birth date:	Group no.:	Policy/certificate no.:
Patient's relationship to subscriber: ❑ Self ❑Spouse ❑ Child ❑Other			

PLEASE COMPLETE BOTH PAGES TO REGISTER

McCabe Denture Implant Solutions

MCCABE DENTURE CLINIC & IMPLANT SOLUTIONS

MEDICAL AND DENTAL HISTORY

(Please Print Clearly. Please email your completed form to info@clinicdenture.com before your appointment, or print a copy and bring it with you.)

MEDICAL HISTORY

Please check if you have problems with, suffer from or have ever had:

- ❑ Allergies
- ❑ Alzheimer's
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood Disorder
- ❑ Blood Pressure
- ❑ Cancer
- ❑ Cholesterol
- ❑ Chronic Pain
- ❑ Depression
- ❑ Diabetes
- ❑ Dry Mouth
- ❑ Epilepsy
- ❑ Eyesight
- ❑ Heart Conditions
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Infectious Disease: _____ _____
- ❑ Injury to face or jaw
- ❑ Jaundice
- ❑ Lung Conditions
- ❑ Migraines
- ❑ Sleep Disorders
- ❑ Stroke
- ❑ Thyroid
- ❑ Tuberculosis
- ❑ Venereal Disease
- ❑ Other (please list below)
- ❑
- ❑
- ❑

Do you smoke? ❑ Yes ❑ No

Please list any allergies below:

_____ _____

_____ _____

_____ _____

_____ _____

Medications you are currently taking (or provide list to reception to copy)**:**

_____ _____

_____ _____

_____ _____

_____ _____

DENTAL HISTORY

Have you worn dentures before? ☐ Yes ☐ No Do you currently have dentures? ❑ Yes ❑ No

If you currently have dentures please indicate which type and how long you've had them:

❑ Full Upper Age of denture ____ ❑ Partial Upper Age of denture ____

☐ Full Lower Age of denture ____ ❑ Partial Lower Age of denture ____

When were your teeth extracted? Upper _____ Lower _____

When was the last time you saw a dentist? _____

The above information is true to the best of my knowledge. I hereby give consent to the attending denturist to proceed with an oral assessment and/or treatment required. I understand that I am financially responsible for any balance. I also authorize McCabe Denture Clinic & Implant Solutions or insurance company to release any information required to process my claims. I'm aware of the available privacy policy at McCabe Denture clinic and understand it is available to read at my request. I understand and agree to the terms and conditions within and give my informed consent for its intended purposes.

Patient Signature *Date*

For Office Use Only: ❑ **Scanned** ❑**Charted**