PATIENT REGISTRATION

Welcome to our office. Your feelings and desires are important to us. We would like for you to assist us by answering the following questions. This information will be of help and will be treated confidentially. Thank you for your patience.

PERSONAL INFORMATION

Name _____ Birthdate (day/mo/yr) _____
(last) (first)
Home Phone_____ Business Phone_____ Cell/Pager_____
Street No. _____ City_____
Province_____ Postal Code_____
Marital status: __Single __Married __Widowed __Divorced __Separated

Person responsible for account: __Self __Spouse __Parent Other_____
Employer_____ Occupation_____
Business Address_____City_____
Spouse's First and Last Name_____ Bus. Phone_____

Do you have Dental Insurance? Yes__ No__
Name of Insurance Co. _____
Group Policy No._____ Certificate No._____
Secondary Insurance Co._____
Group Policy No._____ Certificate No._____
In case of emergency, please notify_____
Relationship_____ Phone No._____

Whom may we thank for referring you? _____

Reason for today's visit: Examination__ Emergency__ Other_____

MEDICAL HISTORY QUESTIONAIRE

Family Physician_____ Phone_____
Address_____ City_____
Medical Specialist_____ Phone_____
Address_____ City_____
Health Card No. (for drug prescriptions) _____

Are you being treated for any medical condition at the present or have you been treated within the last year? Y/N Maybe

Details, if yes _____

_____

When was your last medical check-up? _____

When was your last visit to a physician? _____

Please give reason: _____

Has there been any change in your general health in the past year? Y/N Maybe

Details, if yes, _____

_____

Are you taking any medications or non-prescription drugs of any kind Y/N Maybe

If "yes", please list with dosage:

_____ _____

_____ _____

_____ _____

Do you have any allergies? (E.g. latex) Y/N Maybe

If yes, to what? _____ What kind of reaction? _____

Do you carry an EpiPen? Y/N Maybe

Have you ever had a peculiar or adverse reaction to any medicines or injections? (E.g. penicillin, codeine, aspirin or local anesthetic) Y/N Maybe

Do you have any heart or blood pressure problems? (Please circle) Y/N Maybe

If yes, Explain _____

Do you have a heart murmur or mitral valve prolapse? (Please circle) Y/N Maybe

Have you ever had Rheumatic Fever? Y/N Maybe

If yes, When? _____ How old? _____

Do you have or have you ever had jaundice, hepatitis or liver disease? Y/N Maybe

If yes, Explain _____

Have you ever been told that you should not give blood? Y/N Maybe

If yes, Why? _____

Do you have any conditions that could affect your immune system (E.g. AIDS, HIV positive, leukemias, etc) Y/N Maybe

Do you have a tendency to bruise easily or bleed for a prolonged period of time after being injured? Y/N Maybe

Have you ever been hospitalized for any serious illness or operations? Y/N Maybe

If yes, When? _____ Why? _____

Do you have or have ever had any of the following? Please check off only those that apply.
__chest pain __bronchitis __tuberculosis __arthritis __heart attack __emphysema
__epilepsy __diabetes __stroke __asthma __stomach ulcers
__prosthetic joint __kidney disease __cancer __eating disorder
__drug/alcohol dependency __psychiatric disorder __radiation therapy __chemotherapy
__none of the above
If yes, to any of the above. When? _____

Please list and describe any conditions or diseases not listed in the previous page that you have or have had.

_____

_____

Do you smoke or chew tobacco? Y/N __pack(s)/day If yes. How long? _____

For women:
Are you pregnant? Y/N
If yes, what is the expected date? _____
Are you taking birth control pills? Y/N

Follow-up information to medical questionnaire:

_____

_____

Medical Alert:

DENTAL HISTORY QUESTIONAIRE

Do you have any emotional concerns regarding your dental visit? __anxiety __pain
__time __money __embarrassment __other concerns _____
When was you last dental visit? _____ Last dental x-rays? _____
Previous dentist's name _____Phone No. _____
Address _____ City _____
Reason for changing dentist _____
Have you been seeing a dentist regularly? Y/N Maybe

Do any of your teeth ache? Y/N Maybe
If yes, Where (Upper, Lower, Right, Left) _____
Have you ever been advised to take antibiotics before dental visits? Y/N Maybe
If yes, What kind of medications? _____ Why? _____
Do your gums bleed when you brush? Y/N Maybe
Do you have any pain when you chew? Y/N Maybe
Do you feel that you have bad breath? Y/N Maybe
Have you ever been in a vehicle accident or experienced any blows to your jaw? (Please circle) Y/N Maybe
If yes, When? _____
Have you ever had any implant surgery in one or both of your jaws or jaw joints?
If yes, When? _____ Y/N Maybe
If you have answered "yes" to the last question, who performed the surgery and what part of the mouth? _____
Are you being followed-up by a dental specialist? Y/N Maybe
Details, if yes: _____
Have you ever had orthodontic treatment ("straightening of teeth") in the past? Y/N Maybe
Details, if yes: _____
Please list anything else not mentioned above regarding your past dental history.

_____

Are there any dental concerns you would like to discuss? _____

_____

SMILE EVALUATON: Please circle yes or no to the following questions

I like the appearance of my teeth Y/N
My teeth are in proper alignment (straight) Y/N
I like the shape of my teeth Y/N
I like the colour of my teeth Y/N
My teeth are chipped or malformed Y/N
My fillings are old and I don't like the look of them Y/N
What would you like to change in the appearance of your teeth? _____

ORAL HYGIENE

Do you use an electric tooth brush? Y/N Maybe
Do you use a Fluoride paste or rinse? Y/N Maybe
Brushing frequency(x/day, x/week) _____ Flossing frequency(x/day, x/week)_____

FINANCIAL RESPONSIBILITY

Unless otherwise arranged, payment for service is required on the day of the treatment in rendered.

INSURANCE

In order to prevent misunderstanding about dental insurance, we wish our patients to know that all professional services are CHARGED DIRECTLY TO THE PATIENT and the PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS ON THE DAY treatment is provided. We will prepare necessary reports to help collect your benefits from insurance companies. However, each fee is individual and may vary with different cases. Therefore, collection of benefits may vary slightly.

PATIENT RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I authorize the dentist to release all information necessary to secure payment of benefits from my dental insurance company. I understand that responsibility for payment for the dental services provided for myself and my dependents is mine and I will assume responsibility for fees associated with these services.

Patient (Parent, Guardian) signature _____ Date (d/m/y) _____

Reviewed by Treating Dentist _____ Date (d/m/y) _____