PATIENT REGISTRATION

MEDIC ALERT ______________________

WELCOME TO OUR DENTAL OFFICE

DATE: ______________________

ALL INFORMATION IS CONFIDENTIAL

The following information is required by the dentist to assist in proper diagnosis and treatment.

Please feel free to ask receptionist for help in completing this form.

(Please Print)

PERSONAL INFORMATION This information will enable us to maintain communication with you.

Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ First: ______________________ Last: ______________________

Address: ______________________

City: __________ Prov.: __________ Postal Code: __________ Place of Birth: __________

Date of Birth: ______________________ Height: __________ Weight: __________

Cell: ______________________ E-mail: ______________________

Home: ______________________ Business: ______________________ Ext: __________

How would you like to confirm your appointments? Check off preferred method, maybe more than one.

E-mail ☐ Text ☐ Cell Phone ☐ Home Phone ☐ Business Phone ☐

Occupation: ______________________ Name of Employer: ______________________

How did you hear about our office? ______________________

Reason for today's visit? ______________________

MEDICAL INFORMATION - This information will enable us to make any essential contacts.

Family Physician: ______________________ Phone: __________

Medical Specialist (If presently under care): ______________________ Phone: __________

In case of emergency please contact: ______________________ Phone: __________

Relationship: ______________________

Nearest relative not living with you: ______________________ Phone: __________

FINANCIAL INFORMATION, this information is necessary to process invoices and apply payments.

Person responsible for payment: Self ☐ Spouse ☐ Parent ☐ Other ☐ Name: ______________________

Dental Insurance Yes ☐ No ☐

Primary Dental Insurance

Subscriber's name: ______________________

Employer: ______________________

Date of birth: ______________________

Insurance Company: ______________________

Plan/policy/group number: ______________________

ID/certificate number: ______________________

Secondary Dental Insurance

Subscriber's name: ______________________

Employer: ______________________

Date of birth: ______________________

Insurance Company: ______________________

Plan/policy/group number: ______________________

ID/certificate number: ______________________

1. MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment. All information is confidential.

a. Are you presently under the care of a physician? Yes ☐ No ☐ if yes, explain: ____________________

b. Have you been hospitalized in the last 2 years? Yes ☐ No ☐ Specify: ____________________

c. Do you have a heart or circulatory problem of any kind? Yes ☐ No ☐ Specify: ____________________

d. Have you ever had rheumatic fever? Yes ☐ No ☐ Specify: ____________________

e. Are you presently taking any kind of medication? Yes ☐ No ☐

Specify: A) Drug ____________ B) Drug ____________ C) Drug ____________

Reason ____________ Reason ____________ Reason ____________

f. Do you have or have you ever had a bleeding problem? Yes ☐ No ☐

g. Have you ever taken cortisone or steroids: Yes ☐ No ☐

h. Have you ever had a reaction to any kind of medicine: Yes ☐ No ☐ Specify: ____________________

i. Have you had any organ transplants or medical implants? Yes ☐ No ☐

j. Do you presently or have you ever had:

Aids / HIV	Yes ☐	No ☐	Joint replac. eg. hip, knee	Yes ☐	No ☐	Anaemia	Yes ☐	No ☐
Kidney disease	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐	Liver disease eg. hepatitis	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Lung disease	Yes ☐	No ☐	Blood disorder	Yes ☐	No ☐
Mental or neverous disorder	Yes ☐	No ☐	Cancer	Yes ☐	No ☐	Rheumatism	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Scarlet Fever	Yes ☐	No ☐	Epilepsy/Seizures	Yes ☐	No
Stroke	Yes ☐	No ☐	Heart Attack	Yes ☐	No ☐	Thyroid problem	Yes ☐	No ☐
High/low Blood Pres.	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐	Hyper/hypo glycemia	Yes ☐	No ☐
Venereal disease	Yes ☐	No ☐						

k. Have you ever fainted? Yes ☐ No ☐

l. Have you ever had any illness not mentioned above? Yes ☐ No ☐

Specify: ____________________

2. WOMEN ONLY

1. Are you pregnant? Yes ☐ No ☐ If yes, what month are you in? ____________
2. Are you taking any birth control pills? Yes ☐ No ☐

3. DENTAL HISTORY

1. When was your last dental visit? ____________________
2. How often do you brush? ____________ Floss ____________
3. Have you ever had local anaesthetic? Yes ☐ No ☐ Any complications? ____________
4. Are any of your teeth sensitive to: Cold ☐ Sweets ☐ Heat ☐ Other ☐ ____________
5. Do your gums bleed when: Brushing ☐ Flossing ☐ Spontaneously ☐
6. Do you have any other problems with your teeth not mentioned above? Yes ☐ No ☐

Specify ____________________

PATIENT CERTIFICATION APPROVAL AND CONSENT

I, the undersigned certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. I also consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume responsibility for fees associated with these procedures. I also consent to my physician being contacted if necessary, as this information may be required for my dental care.

Patient (Parent, Guardian) Signature ____________________ Date: ____________

IN ORDER TO AVOID COMPLICATIONS AS A RESULT OF A CHANGE IN YOUR MEDICAL CONDITION, IT IS IMPORTANT THAT YOU NOTIFY OUR OFFICE OF THESE CHANGES.