Date

WELCOME TO OUR OFFICE

REGISTRATION INFORMATION

PID: #

MEDICAL ALERT Y N

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form.

REGISTRATION INFORMATION

The patient is an: Adult Child Adult under guardianship Name of Guardian:

Name: Last, First Initial Dr. Mr. Mrs. Ms. Miss

Address: Street Address 2: Street City and Prov/State Zip/Postal code

Reason for today's visit? Examination Emergency Other

Is there a dental problem you would like treated immediately? Preferred appt. time?

Home Phone: Cell Phone: Pager No:

Bus. Phone: Ext. Employer: May we call you at work? Yes No

E-mail address:

Prefers to be called: Occupation:

Date of Birth: M. D. Y. Age: Sex: Marital Status: Name of Spouse:

Are other family members patients at our office? Yes Names:

Whom may we thank for referring you?

Family Physician:

Medical Specialist: Phone:

(if presently under care)

In case of emergency, please contact: Phone:

Nearest relative not living with you: Phone:

Phone:

FINANCIAL & CREDIT INFORMATION

Person responsible for account: Self ○ Spouse ○ Other ○

Name: Last, First _____ Initial _____ Home Phone: _____

Address: Street _____ Address 2: Street _____ City and Prov/State _____ Zip/Postal Code _____

Employed by: _____ Phone: _____

Driver's Lic. No. _____ S.S.N. _____ Credit Card No: _____ Expiry Date: _____

PRIMARY DENTAL INSURANCE (if information available) SECONDARY DENTAL INSURANCE

Subscriber's name: _____ **D.O.B.** _____ **Subscriber's name:** _____ **D.O.B.** _____

Emp./Grp. policy holder: _____ **Ins. yr. end** _____ **Emp./Grp. policy holder:** _____ **Ins. yr. end** _____

Ins. Co. _____ **Tel.** _____ **Ins. Co.** _____ **Tel.** _____

Grp./Ind. policy No. _____ **Cert. No.** _____ **Grp./Ind. policy No.** _____ **Cert. No.** _____

DENTAL HISTORY

Please check YES or NO to each question. If unsure of a question, please consult the dentist.

Is there a dental problem you would like treated immediately? Yes ○ No ○ _____

Date of your last dental visit? _____ Last dental cleaning? _____ Last x-rays? _____

		YES	NO
1.	Are you having regular dental visits? _____	○	○
2.	Have you ever had any of the following? ☐ Periodontal Treatment (treatment of gums)? ☐ Orthodontic Treatment (to straighten or realign teeth)? ☐ A bite plate or any other appliance? ☐ Your bite adjusted or teeth ground? ☐ Oral Surgery (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints)?		
3.	How often do you brush your teeth? _____ Do you feel that you have bad breath? _____	○	○
4.	Do you use dental floss, proxabrush or stimudents? _____ How often? _____	○	○

5. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums?

6. Does food catch between your teeth?

7. Are any of your teeth sensitive to heat, cold, sweets or pressure?

8. Have you ever experienced any of the following jaw problems?

- ☐ Popping/clicking in your jaw joints?
- ☐ Pain in your jaw joints, around your ear, or side of your face?
- ☐ Difficulty in opening or closing?
- ☐ Pain when teeth are clenched?
- ☐ Pain or difficulty when chewing?

9. Do you have any of the following habits?

- ☐ Clenching or grinding your teeth while awake or asleep?
- ☐ Biting your cheeks or lips?
- ☐ Mouth breathing while awake or asleep?
- ☐ Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails) ?

10. Do you have any emotional concerns about having dental treatment?

11. Are you unhappy with the appearance of your teeth?
What would you like to see changed?

12. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns?

HEALTH HISTORY

Please check YES or NO to each question.

1. Are you being treated for any medical condition at present or within the past year?
If yes, please explain:

2. Has there been any changes in your general health in the past year?

3. When was your last visit to a Physician? Last complete physical examination?

List any PRESCRIPTION or NON-PRESCRIPTION drugs you are taking or have recently taken (including birth control pills):

4.

5. Have you ever had any adverse or unusual reaction to any medications or injections? (e.g. penicillin, or other antibiotics, aspirin, codeine, local anesthetic ("dental freezing")? Please explain:

6. Have you ever been advised against taking any specific type of medication?

Do you have any allergies (e.g. hay fever, food allergies, latex/rubber or metal allergies)?

7.

8. Have you ever fainted during dental or medical treatment?

9. Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders?
Please explain:

10. Are you on cortisone or steroid therapy, or, are you on a diet pill therapy?

11. Do you have any artificial joints (e.g. hip, knee)?

12. Have you ever been advised to take antibiotics before dental treatment?

13. Do you have a heart murmur, valve dysfunction (mitral valve prolapse or artificial heart valve) or have you ever had Rheumatic Fever?

14. Do you have, or have you ever had, any heart or blood pressure problems (heart or stroke)?
Please explain:

15. Do you have or have you ever had any chest pain, shortness of breath or any heart palpitation without exertion?

16. Are you presently suffering from any infectious diseases?

17. Do you have any condition that could affect your immune system (e.g. arthritis, AIDS, HIV infection, lupus, inflammatory bowel disease, Crohn's disease)? Please specify:

Have you ever had any malignant disease, or are you presently undergoing any radiation treatment/chemotherapy?

18.

19. Indicate which of the following you presently have, or ever had: **(Please check all that apply)**

Asthma ☐	**Epilepsy or Seizures** ☐	**Tuberculosis** ☐	**Glandular Disorders** ☐
Bronchitis ☐	**Hepatitis** ☐	**Diabetes** ☐	**Organ Transplant/Medical Implant** ☐
Emphysema ☐	**Jaundice** ☐	**Kidney Disease** ☐	**Stomach/Intestinal Problems** ☐
Lung Disease ☐	**Liver Disease** ☐	**Thyroid Disease** ☐	**Ulcers** ☐

20. Do you, or did you smoke? ☐ Do you drink alcoholic beverages on a regular basis? ☐ Use Recreational Drugs? ☐

21. **WOMEN ONLY:** Are you pregnant? ☐ If pregnant, delivery date? ☐ Are you breast feeding? ☐

Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer, heart disease)?

22. ☐ ○ ○

Do you currently have, or ever had in the past, any disease, condition or problem not listed above?

23. ☐ ○ ○

Is there anything else about your health we should be made aware of; or do you wish to speak to the doctor privately about any problem or medical condition?

24. ☐ ○ ○

NOTES: ☐

GENERAL 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. **Should there be any change in my health**

status in the future, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

(signature) Patient ☐ Parent ☐ Guardian ☐

(print name of guardian)

Date:

Reviewed by Treating Dentist: