Patient I.D. # _____

Date: ____/____/____ (M / D / Y)

WELCOME TO OUR OFFICE

PATIENT REGISTRATION **ALL INFORMATION IS CONFIDENTIAL**

The following information is required by the dentist to assist in proper diagnosis and treatment. Please feel free to ask the receptionist for help in completing this form. PLEASE PRINT.

ADULT PATIENT (or Parent/Guardian) REGISTRATION ❒ Dr. ❒ Mr. ❒ Mrs. ❒ Ms. ❒ Miss ❒ Other _____

Are you the ❒ PATIENT ❒ PARENT ❒ GUARDIAN

Name: _____ (last) (first) (initial)

Address: _____ (street) (city) (prov./state) (postal/zip code)

Date of Birth: ___/___/___ (M/D/Y) Age: ___ Sex: ___ Martial Status: _____ Home Phone: ( ) _____

Driver's License No.: _____ Work Phone: ( ) _____ Ext. _____

Employer: _____ Cell Phone: ( ) _____

Who can we thank for the referral? _____

How did you hear about our office? _____

E-mail address: _____

Permission to send e-mail newsletter? (please sign) _____

CHILD REGISTRATION or ADULT UNDER GUARDIANSHIP

Name: _____ (last) (first) (initial) Prefers to be called

Address: _____ (if different than above) (street) (city) (prov./state) (postal/zip code)

Date of Birth: ___/___/___ (M/D/Y) Age: _____ Sex: _____ Home Phone: ( ) _____

School: _____ Grade: _____

Person responsible for account: ❒ Self ❒ Spouse ❒ Other If other, please complete the following:

Method of payment: ❒ Cash ❒ Cheque ❒ Credit Card

Name: _____ Home Phone: ( ) _____

Address: _____ (street) (city) (prov./state) (postal/zip code)

Employer: _____ Work Phone: ( ) _____ Ext. _____

Spouse's Name: _____ Occupation: _____

Employer: _____ Phone: ( ) _____

In case of emergency, contact: _____ Work Phone: ( ) _____ Ext. _____

Closest family relative: _____ Phone: ( ) _____

Is another family member or relative a patient at our office? _____

PRIMARY DENTAL INSURANCE

NAME OF INSURED	DATE OF BIRTH	
EMPLOYER		
INSURANCE CARRIER		
GROUP/POLICY NUMBER		
I.D. NUMBER OR S.I.N.	CERTIFICATE NUMBER	DEPT. NO.
COVERAGE PERCENTAGE: A B C D		
LIMITS BASIC MAJOR ORTHO		
DEDUCTIBLE BASIC MAJOR	❒ PER PERSON ❒ PER FAMILY	
COMP COV N/G	uSc/Rp ONLAY	mR

SECONDARY DENTAL INSURANCE

NAME OF INSURED	DATE OF BIRTH	
EMPLOYER		
INSURANCE CARRIER		
GROUP/POLICY NUMBER		
I.D. NUMBER OR S.I.N.	CERTIFICATE NUMBER	DEPT. NO.
COVERAGE PERCENTAGE: A B C D		
LIMITS BASIC MAJOR ORTHO		
DEDUCTIBLE BASIC MAJOR	❒ PER PERSON ❒ PER FAMILY	
COMP COV N/G	uSc/Rp ONLAY	mR

MEDICAL HISTORY

Date: _____ / _____ / _____
M D Y

MEDIC ALERT	

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

	Yes	Don't Know/ Maybe	No
1. Have you ever had a serious illness requiring hospitalization or extensive medical care? Specify: _____	❒	❒	❒
2. Are you presently under the care of a physician?	❒	❒	❒
3. Have you had a medical examination in the past year?	❒	❒	❒
4. Do you use any prescription or non-prescription medicine regularly? Specify: _____	❒	❒	❒
5. Do you have any allergic condition, i.e. asthma, hay fever, skin rash, food allergies, etc.?	❒	❒	❒
6. Do any allergic reactions result in headache, shortness of breath, chest constriction, nausea? Specify: _____	❒	❒	❒
7. Have you been hospitalized in the last 5 years?	❒	❒	❒
8. Have you ever experienced any unusual reaction to any of the following? (Please circle): Local anaesthesia (freezing), aspirin, penicillin, iodine, sulfonamide, barbiturates (sleeping pills), or any other medicine? If so, explain: _____	❒	❒	❒
9. Have you been warned against taking any drug or medication?	❒	❒	❒

10. Do you have or have you ever had any of the following? (please check ✔)

❒ Heart murmur or mitral valve prolapse	❒ High/low blood pressure	❒ Venereal disease	❒ Jaundice	❒ Sinus trouble
❒ Stomach/ intestinal problems	❒ Hyper- (or hypo-) glycemia	❒ Any lung disease	❒ Diabetes	❒ Liver disease
❒ Joint replacement (hip, knee, etc.)	❒ Epilepsy or seizures	❒ Thyroid disease	❒ Tuberculosis	❒ Cortisone/steroid therapy
❒ Mental or nervous disorder	❒ Malignant hyperthermia	❒ Arthritis or rheumatism	❒ Stroke	❒ Other _____
	❒ Drug/alcohol addiction	❒ Scarlet or rheumatic fever	❒ Hepatitis A/B/C	_____
		❒ AIDS	❒ Herpes	_____
		❒ Positive test for HIV	❒ Heart attack	_____
			❒ Cold sores	_____
			❒ Cancer	
			❒ Kidney disease	

11. Have you ever had any known contact with the AIDS virus (HIV)?	❒	❒	❒
12. Has any member of your family had diabetes?	❒	❒	❒
13. Do you bruise easily or bleed abnormally?	❒	❒	❒
14. Do your ankles swell during the day?	❒	❒	❒
15. Have you had any weight changes recently?	❒	❒	❒
16. Do you have any blood disorders such as anemia (thin blood), thalassaemia (major, minor)?	❒	❒	❒
17. Have you ever had radiation treatment or chemotherapy? If so, explain _____	❒	❒	❒
18. Have you ever had any injury, surgery, or x-ray therapy to your face or jaws?	❒	❒	❒
19. Do you have frequent severe headaches?	❒	❒	❒
20. Do you have frequent earaches, ear/throat infections, or any hearing difficulties?	❒	❒	❒
21. Is your eyesight: ❒ Good ❒ Adequate ❒ Poor Do you wear contact lenses?	❒	❒	❒
22. Are you on a special diet?	❒	❒	❒
23. Have you ever fainted?	❒	❒	❒
24. Do you ever experience shortness of breath or chest pain when walking or climbing stairs? If so, explain _____	❒	❒	❒
25. Have you had any organ transplants or medical implants?	❒	❒	❒
26. Do you have any disease, condition, or problem that you think the dentist should know about? If so, explain _____	❒	❒	❒
27. Is there anything about yourself that we should be made aware of? If so, explain _____	❒	❒	❒
28. WOMEN ONLY - Are you pregnant? _____ If so, which month are you in? _____ Are you taking birth control pills?	❒	❒	❒

TO AVOID COMPLICATIONS, PLEASE NOTIFY OUR OFFICE OF ANY CHANGE IN YOUR MEDICAL CONDITION.

DENTAL HISTORY

Date: ____/____/____ (M / D / Y)

MEDIC ALERT

1. Reason for today's visit: ❒ Exam ❒ Cleaning ❒ Emergency ❒ Other _____
   Is there a dental problem you would like to have taken care of as soon as possible? _____
2. How frequently do you see your dentist? ❒ 6 months ❒ Yearly ❒ Other _____
   Former dentist _____ Last dental visit _____
   Last cleaning _____ Last full-mouth series of x-rays _____ X-rays requested _____
3. Have you been given oral hygiene instruction in: ❒ Brushing ❒ Flossing
   ❒ Other _____ By whom? _____
4. Brushing: ❒ Vigorous ❒ Light How often? _____ Type of brush? _____
5. How often do you floss your teeth? _____
6. Other cleaning aids used: ❒ Floss ❒ Stimudents ❒ Toothpick ❒ Other _____
7. Are any of your teeth sensitive to: ❒ Cold ❒ Sweets ❒ Heat ❒ Other _____
8. Do your gums bleed when ❒ Brushing ❒ Flossing ❒ Spontaneously
9. Have you ever had or do you now have any of the following? (please check ✔)

❒ Bridges	❒ Extractions	❒ Swelling or pain in your mouth or jaws	❒ Gagging easily
❒ Partial dentures	❒ Loose teeth	❒ Injuries to your face or jaws	❒ Difficulty opening or closing your jaw
❒ Full dentures	❒ Orthodontic treatment	❒ Surgery in your mouth	
❒ Root canal fillings	❒ Bite adjustment	❒ Gum treatments	
❒ Dental implants	❒ Bite appliance/ night guard		
❒ Lost fillings			

	Yes	Don't Know/ Maybe	No
10. Are you satisfied with the **shape** of your teeth?	❒	❒	❒
11. Are you satisfied with the **colour** of your teeth?	❒	❒	❒
12. Are you satisfied with the **position** of your teeth?	❒	❒	❒
13. Are you satisfied with the **size** of your teeth?	❒	❒	❒
14. Does your jaw crack or pop when opened widely?	❒	❒	❒
15. Do you: Grind or clench your teeth during the day or night?	❒	❒	❒
Mouth breate while awake or asleep?	❒	❒	❒
Bite your lips or cheeks regularly?	❒	❒	❒
Hold any foreign objects with your teeth? (i.e., pipe, pencils, nails, etc.)	❒	❒	❒
Smoke? ❒ Cigarettes ❒ Cigars ❒ Pipe ❒ Other	❒	❒	❒
Number per day _____			

16. Check (✔) any of the following you are interested in or you have thought about:

❒ Orthodontics (braces)	❒ Repairing chipped teeth	❒ Improved gum health
❒ Bonding (straightening)	❒ Tooth whitening	❒ Improving your bite
❒ Closing spaces between teeth	❒ Crowns (caps)	❒ Improving breath odor
❒ Replacing missing teeth	❒ Sports mouth guard	❒ Improving your smile

17. Would you like to discuss what options are available to improve your SMILE? ❒ Yes ❒ No
18. Do you have any emotional concerns regarding your dental visit? ❒ Fear ❒ Pain ❒ Time
    ❒ Money ❒ Embarrassment ❒ Other concerns _____

INFORMED CONSENT/GENERAL RELEASE

I, the undersigned, state that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical/Dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services, including the use of anaesthetic as be necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services.

Patient (Parent, Guardian) Signature: _____

If parent or guardian*, please print name: _____ Date: ____/____/____ (M / D / Y)

*Guardian of Child or Guardian of Adult under Guardianship

MEDICAL HISTORY UPDATE

If there is a change, record in medical history.

Date	Same	Change	Patient Signature	Dr. Initials
_____	❒	❒	_____	_____
_____	❒	❒	_____	_____
_____	❒	❒	_____	_____
_____	❒	❒	_____	_____

Date	Same	Change	Patient Signature	Dr. Initials
_____	❒	❒	_____	_____
_____	❒	❒	_____	_____
_____	❒	❒	_____	_____
_____	❒	❒	_____	_____