PATIENT REGISTRATION FORM

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

PATIENT IDENTIFICATION Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Miss
☐ Mr
☐ Mrs.
☐ Ms.
☐ Dr.

Last Name First Name(s) Preferred Name

Date of Birth (Month/Day/Year) Parent/Guardian Name (if under 18)

CONTACT ADDRESS

Street No. and Name Unit No. City Province Postal Code

CONTACT NUMBER Preferred Contact Method: ☐ Home ☐ Mobile ☐ Work ☐E-mail

Home Mobile E-mail Address

WORK INFORMATION

Your Occupation Work Phone Number (Include extension)

FAMILY PHYSICIAN INFORMATION

Name Street No, Name and Unit No. City Province Contact No.

EMERGENCY CONTACT INFORMATION

Name Relationship to Patient Contact No.

WHO MAY WE THANK FOR YOUR REFERRAL?

☐ Patient: _____ ☐ Others: _____

REASON FOR TODAY'S VISIT	☐ Consultation ☐ Emergency ☐ Cleaning and Checkup ☐ Others: _____
Who will be responsible for patient's account? ☐ Self ☐ Insurance	☐Government Program: _____ ☐Other (s) : _____
If insurance or Government Assistance will be responsible for patient's account, kindly provide the account information below:	

PRIMARY INSURANCE	**SECONDARY INSURANCE**
_____ Subscriber's Name Insurance Carrier _____ Policy Number Certificate number _____ Date of Birth (m/d/y)	_____ Subscriber's Name Insurance Carrier _____ Policy Number Certificate number _____ Date of Birth (m/d/y)

PATIENT REGISTRATION **MEDICAL AND DENTAL HISTORY**

ALL INFORMATION IS CONFIDENTIAL

DENTAL HISTORY

Last Dental visit:_____ Last dental cleaning:_____ Last x-ray taken:_____

Is there a dental problem you would like treated immediately?	☐ Yes	☐No
Are you seeing a dentist regularly?	☐ Yes	☐No
Have you ever had local anaesthetic (Freezing)?	☐ Yes	☐No
Were there any complications from the local anaesthetic? If yes, please provide details	☐ Yes	☐No
Do any of your teeth ache, and/or are sensitive to heat, cold, sweets or pressure?	☐ Yes	☐No
Do your gums bleed when brushing or eating?	☐ Yes	☐No
Have you noticed any loose teeth or teeth shifting?	☐ Yes	☐No
Have you ever been advised to take antibiotics before dental appointments? If yes, please provide details:	☐ Yes	☐No
_____		
Have you ever had any implant surgery in your jaws or jaw joints?	☐ Yes	☐No
Are you being followed-up by a dental specialist? If yes, please provide details:	☐ Yes	☐No
_____		
Do you feel that you have bad breath?	☐ Yes	☐No
Have you ever had any problems with your previous dental work? If yes, please provide details:	☐ Yes	☐No
_____		

MEDICAL HISTORY

Are you being treated for any medical condition at the present or have you been treated within the last year? _____	☐ Yes	☐No
Has there been any change in your general health in the past year? If yes, please specify:	☐ Yes	☐No
_____		
Are you taking medication (Prescription drugs, vitamins, or herbal alternatives)? If yes, please specify: _____	☐ Yes	☐No
Have you ever had a peculiar or adverse reaction to any medicines or injections (e.g. Penicillin, aspirin or local anesthetics such as dental freezing)? If yes, please provide details:	☐ Yes	☐No
_____		
Do you have any allergies? If yes, please specify:	☐ Yes	☐No
_____		
Do you bleed excessively from a cut or injury, or bruise easily?	☐ Yes	☐No
Do your ankles, feet, or hands swell?	☐ Yes	☐No
Do you have or have you had any of the following: heart murmur, heart attack, heart surgery, angina pectoris, mitral valve prolapse, congenital heart lesions, or rheumatic heart disease?	☐ Yes	☐No
Do you experience shortness of breath or chest pain when walking or climbing stairs?	☐ Yes	☐No
Do you have stomach issues or GERD?	☐ Yes	☐No
Have you ever been hospitalized for any serious illness or operations? If please provide details:	☐ Yes	☐No
_____		
Do you smoke or chew tobacco?	☐ Yes	☐No
Are you alcohol and/ or drug dependent?	☐ Yes	☐No
Have you received treatment for alcohol or drug dependency?	☐ Yes	☐No
Have you ever tested positive for HIV?	☐ Yes	☐No

DO YOU, OR DID YOU IN THE PAST, HAVE ANY OF THE FOLLOWING HEALTH CONCERNS? PLEASE CHOOSE:

Arthritis	☐ Yes ☐No	Epilepsy	☐ Yes ☐No	Low BP	☐ Yes ☐No	Sinus Trouble	☐ Yes ☐No
Asthma	☐ Yes ☐No	Emphysema	☐ Yes ☐No	Jaundice	☐ Yes ☐No	Steroids	☐ Yes ☐No
Anaemia	☐ Yes ☐No	Fainting	☐ Yes ☐No	Kidney disease	☐ Yes ☐No	Stroke	☐ Yes ☐No
Bronchitis	☐ Yes ☐No	Herpes	☐ Yes ☐No	Liver disease	☐ Yes ☐No	Thyroid	☐ Yes ☐No
Cancer	☐ Yes ☐No	Hepatitis A B,C,D	☐ Yes ☐No	Pacemaker	☐ Yes ☐No	Tuberculosis	☐ Yes ☐No
Diabetes	☐ Yes ☐No	High BP	☐ Yes ☐No	Pneumonia	☐ Yes ☐No	Other	☐ Yes ☐No

To the best of my knowledge, the information above is true and correct.

_____	_____	_____	_____
Signature	**Print name of signatory**	**Date signed (mm/dd/yyyy)**	**Reviewing Dentist**