DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date: _____

Patient _____

Address _____

_____

City Prov. PC

Sex ☐ M ☐ F Age _____ Birth Date _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Email address: _____

Occupation _____

Employer _____

Employer Phone _____

Spouse's Name _____

Birth Date _____

Occupation _____

Whom may we thank for referring you? _____

_____

_____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____ ID # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birth Date _____ SIN# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____ ID # _____

How much is your Deductible _____

RELEASE: I understand that I am financially responsible for all charges whether or not paid by insurance.

_____

Responsible Party Signature

_____ _____

Relationship Date

3 PHONE NUMBERS

Phone _____ Work _____ Ext. _____ Cell _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household) _____

Name _____ Relationship _____ Home Phone _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "YES" or "No" to indicate if you have had any of the following:

Bad Breath ☐ Yes ☐ No

Bleeding Gums ☐ Yes ☐ No

Blisters on lips or mouth ☐ Yes ☐ No

Do you like your smile ☐ Yes ☐ No

If no explain why _____

Do you get headaches ☐ Yes ☐ No

If yes how often _____

Do you smoke cigarette, cigar or pipe ☐ Yes ☐ No

Do you chew on one side of mouth ☐ Yes ☐ No

Food Collection between teeth ☐ Yes ☐ No

Bleeding when you brush ☐ Yes ☐ No

Periodontal treatment ☐ Yes ☐ No

Sensitivity to cold/hot ☐ Yes ☐ No

Sensitivity to sweets ☐ Yes ☐ No

Sensitivity when biting ☐ Yes ☐ No

Gum swollen or tender ☐ Yes ☐ No

Lip or Cheek biting ☐ Yes ☐ No

Mouth breathing ☐ Yes ☐ No

Orthodontic treatment ☐ Yes ☐ No

Pain around ear ☐ Yes ☐ No

Clicking or popping jaw ☐ Yes ☐ No

Dry mouth ☐ Yes ☐ No

Jaw pain or tiredness ☐ Yes ☐ No

Do you snore ☐ Yes ☐ No

Do you grind your teeth at night ☐ Yes ☐ No

Do you think you sleep well and wake up rested ☐ Yes ☐ No

How often do you floss? _____

How often do you brush? _____

What do you consider your dental knowledge

Minimal ☐ Fair ☐ Good ☐

Do you have any emctional concerns regarding your visit

Fear ☐ Time ☐ Pain ☐ Money ☐

— OVER —

5 MEDICAL HISTORY (this information will remain confidential)

1. Are you presently under the care of a physician? ☐ Yes ☐ No If yes, explain. _____
2. Have you ever been hospitalized? ☐ Yes ☐ No If yes, explain. _____
3. Have you ever had any adverse effect to any of the following: **Antibiotic** - Penicillin ☐, Sulfonamide ☐, Other ☐, **Aspirin** ☐, **Barbiturates** (sleeping pills) ☐, **Codeine** ☐, **Darvon** ☐, **Local Anaesthetic** ☐, **None** ☐.
4. Have you ever been warned against using any other medications? ☐ Yes ☐ No If yes, which? _____
5. Have you ever taken prolonged medical or non-medical drugs? ☐ Yes ☐ No If yes, which? _____
6. Do you bruise easily or have prolonged bleeding? ☐ Yes ☐ No
7. Have you ever fainted, had shortness of breath or chest pains? ☐ Yes ☐ No
8. WOMEN ONLY: Are you pregnant? ☐ Yes ☐ No Using birth control? ☐ Yes ☐ No Reached menopause? ☐ Yes ☐ No
9. Do you have or have you ever had any of the following? Please check the appropriate boxes for yes.

- ☐ A.I.D.S.
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints (hips, knees)
- ☐ Asthma
- ☐ Blood disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy/Radiation
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone/Steroid Treatments
- ☐ Diabetes
- ☐ Drug/alcohol dependence
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glandular disorders
- ☐ Glaucoma
- ☐ Head/Neck injuries
- ☐ Heart disease/attack
- ☐ Heart murmur
- ☐ Heart pacemaker/surgery
- ☐ Heart rhythm disorder
- ☐ Hepatitis A/B/C
- ☐ Herpes
- ☐ High/Low blood pressure
- ☐ HIV positive
- ☐ Hodgkin disease
- ☐ Hyper (Hypo) Glycemia
- ☐ Hypertension
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Leukemia
- ☐ Lung disease
- ☐ Malignant hypothermia
- ☐ Mental/nervous disorder
- ☐ Mitral valve prolapse
- ☐ Organ transplant/implant
- ☐ Psychiatric disorders
- ☐ Rheumatic/Scarlet fever
- ☐ Sickle Cell disease
- ☐ Sinus Trouble
- ☐ Stomach/intestinal problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Other
- ☐ None

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

_____

Pharmacy Name _____ Phone: _____

ALLERGIES

_____

_____

_____

_____

_____

6 INFORMED CONSENT / GENERAL RELEASE

I have answered the questions on both sides of this form and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding these questions and I consent to my physician being contacted if necessary. I authorize the dentist to perform the procedures and services necessary including the use of anaesthetic. I also authorize the communication of information related to the coverage of services described on this form to the named dentist.

Signature: _____ _____

☐ Patient ☐ Parent ☐ Guardian MONTH DAY YEAR

We appreciate you taking the time to answer these questions