WELCOME TO OUR DENTAL OFFICE

(For office use only)

I.D. #	
MEDICAL ALERT Y ☐ N ☐	

Date ____________________

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. PLEASE PRINT.

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) (apt.#) (city) (province) (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: ( ) ____________ Driver's Lic. No. ____________ S.I.N. ____________

Bus. Phone: ( ) ____________ Ext. ____ Employer: ____________ May we call you at work? ☐

Cell Phone: ( ) ____________ Pager No: ( ) ____________ E-Mail address: ____________

PERSONAL INFORMATION

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? ____________

MEDICAL PRIORITY

Family Physician: ____________ Phone: ( ) ____________

Medical Specialist: ____________ Phone: ( ) ____________
(if presently under care)

In case of emergency, please contact: ____________ Phone: ( ) ____________

Nearest relative not living with you: ____________ Phone: ( ) ____________

FINANCIAL INFORMATION

Person responsible for account: Self ☐ Spouse ☐ Other ☐ Please complete all information if different than above.

Name: (last) (first) (initial) Phone: ( ) ____________

Address: (street) (apt.#) (city) (province) (postal code)

Employed by: ____________ Phone: ( ) ____________

Driver's Lic. No. ____________ S.I.N. ____________

PRIMARY DENTAL INSURANCE (If information available) SECONDARY DENTAL INSURANCE

Primary					Secondary				
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.		
I.D./S.I.N.		Max. Coverage.			I.D./S.I.N.		Max. Coverage.		
% coverage: Basic	Maj. Rest.	Ortho.	Other	Other	% coverage: Basic	Maj. Rest.	Ortho.	Other	Other

METHOD OF PAYMENT (For office use only) CASH ☐ CHEQUE ☐ CREDIT CARD ☐ OTHER ☐

PATIENT REGISTRATION DENTAL HISTORY

Name:	D.O.B. M D Y	Patient/Parent/Guardian Initial:	Date: M D Y

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

1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: ______ Physician: ______ Phone: ______ ☐ ☐
2. Have you been hospitalized in the past two years? ______ ☐ ☐
3. When was your last visit to a Physician? ______ Last complete physical examination? ______
4. Have you recently, or are you presently, taking any PRESCRIPTION or NON-PRESCRIPTION drugs? Please list: ☐ ☐
   1. ______ 2. ______ 3. ______
   4. ______ 5. ______ 6. ______
5. Have you ever reacted adversely to any of the following? (Please circle.) ANTIBIOTICS - Penicillin, Sulfonamide, other antibiotics, ASPIRIN, BARBITURATES (sleeping pills), CODEINE, DARVON, LOCAL ANAESTHETIC (freezing), NITROUS OXIDE, any other medicine: ______ ☐ ☐
6. Have you ever been advised against taking any specific type of medication? ______ ☐ ☐
7. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions? ______ ☐ ☐
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain: ______ ☐ ☐
9. Has any family member had diabetes? ______ ☐ ☐
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? ______ ☐ ☐
11. Do your ankles, feet or hands swell? ______ ☐ ☐
12. Has your weight, appetite or energy level changed dramatically recently? ______ ☐ ☐
13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? ______ ☐ ☐
14. Do you follow a special diet? ______ ☐ ☐
15. Have you tested HIV positive? ______ ☐ ☐
16. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? ______ ☐ ☐
17. Have you ever had any injury or surgery to your face or jaws? ______ ☐ ☐
18. Do you wear eyeglasses or contact lenses? ______ ☐ ☐
19. Do you have any hearing difficulties? ______ ☐ ☐
20. Do you smoke or use any other forms of tobacco? ______ ☐ ☐
    Are you wearing the transdermal nicotine patch? ______ ☐ ☐
21. Are you alcohol and/or drug dependent? ______ ☐ ☐
    and, Have you received treatment? ______ ☐ ☐
22. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

	YES	NO		YES	NO		YES	NO
A.I.D.S.	☐	☐	Head/neck injuries	☐	☐	Mental/nervous disorder	☐	☐
Anemia	☐	☐	Heart disease or attack	☐	☐	Mitral valve prolapse	☐	☐
Angina pectoris	☐	☐	Heart murmur	☐	☐	Organ transplant/medical implant	☐	☐
Arthritis/rheumatism	☐	☐	Heart pacemaker	☐	☐	Psychiatric treatment	☐	☐
Artificial heart valve	☐	☐	Heart rhythm disorder	☐	☐	Radiation treatment/chemotherapy	☐	☐
Artificial joints(hip, knee)	☐	☐	Heart surgery	☐	☐	Rheumatic/Scarlet fever	☐	☐
Blood disorders	☐	☐	Hepatitis A B C ______	☐	☐	Sickle cell disease	☐	☐
Bronchitis	☐	☐	Herpes	☐	☐	Sinus trouble	☐	☐
Cancer	☐	☐	High/Low blood pressure	☐	☐	Stomach/intestinal problems/Ulcers	☐	☐
Circulation problems	☐	☐	Hodgkins disease	☐	☐	Stroke	☐	☐
Congenital heart lesions	☐	☐	Hyper (Hypo) Glycemia	☐	☐	Thyroid disease	☐	☐
Cortisone/steroid	☐	☐	Hypertension	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Jaundice	☐	☐	Venereal Disease	☐	☐
Emphysema	☐	☐	Kidney disease	☐	☐	Other ______	☐	☐
Epilepsy or seizures	☐	☐	Liver disease	☐	☐	Other ______	☐	☐
Fainting or dizzy spells	☐	☐	Lung disease	☐	☐			
Glandular disorders	☐	☐	Lupus	☐	☐			
Glaucoma	☐	☐	Malignant Hyperthermia	☐	☐			

23. Has the CHILD PATIENT recently had any of the following: (indicate approximate date.)

	YES	NO		YES	NO
Measles ______	☐	☐	Strep throat ______	☐	☐
Mumps ______	☐	☐	Tonsillitis ______	☐	☐
Chicken Pox ______	☐	☐			

24. WOMEN ONLY: Are you pregnant or suspect you may be? ______ ☐ ☐
    If yes, what is the expected delivery date? ______ Are you taking any birth control pills? ______ ☐ ☐

25. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? ______ ☐ ☐
26. Is there anything else about your health we should be made aware of? ______ ☐ ☐
27. Do you wish to speak to the Doctor privately about any problem or medical condition? ______ ☐ ☐

MEDICAL HISTORY **MEDICAL HISTORY UPDATES**