

WELCOME TO OUR OFFICE

PATIENT REGISTRATION

DATE: _____

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of care. Please answer all questions as accurately as you can. If you have any questions or doubts, please ask my staff, who are available to assist you with the completion of this form. All information is strictly confidential and will remain with this office.

PLEASE PRINT.

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

Mr. Mrs. Ms. Miss Dr. Date of Birth: Month _____ Day _____ Year _____ Age: _____

Name: (last) _____ (first) _____ (middle initial) _____ (Prefer to be called) _____

Address: (P) _____ (street) _____ (city) _____ (province) _____ (postal code) _____

Home Phone: _____ Occupation: _____ Citizenship: _____

May we call you at work? Yes No Bus. Phone: _____ School: _____

Sex: Male Female Health Card No: _____

Family Physician: _____ Phone: () _____

Medical Specialist: _____ Phone: () _____

Referring Dentist: _____ Phone: () _____

In case of emergency, please notify: _____

Relationship: _____ Phone: () _____

Closest family relative: _____ Phone: () _____

Person responsible for account: Self Spouse Parent Other

Do you have dental insurance? Yes No Insurance Co.: _____

Policy No. _____ Division No. _____ Certificate/ID No. _____

Insurance Policy Holder's Information

Name: (last) _____ (first) _____ (middle initial) _____ D. O. B. _____

Address: (P) _____ (street) _____ (city) _____ (province) _____ (postal code) _____

Home Phone No: () _____ Employer _____

Do you have any other dental coverage? Yes _____

HEALTH HISTORY

Please Yes or No to each question. If you are unsure of a question, please consult with the Doctor.

YES NO

- 1. Are you being treated for any medical condition at the present time?
- 2. Have you been treated within the past year? If so, why? _____
- 3. When was your last medical checkup? _____
- 4. Has there been any change in your general health in the past year? If yes, please explain. _____
- 5. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
If yes, please list: 1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
- 6. Do you have any allergies? If you answered yes, please list using the categories below:
 Medications latex/rubber products other (e.g. hay fever, foods)
List: _____
- 7. Have you ever had a peculiar or adverse reaction to any medicines or injections?
If yes, please explain. _____

(Continued on Back)

YES NO

- 8. Do you have or have you ever had asthma?
- 9. Do you have or have you ever had any heart or blood pressure problems?
- 10. Do you have or have you ever had any of the following (please check):
 - an artificial heart valve an infection of the heart (i.e. infective endocarditis)
 - a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
- 11. Do you have a prosthetic or artificial joint? If so, year placed _____
- 12. Do you have any conditions or therapies that could affect your immune system?
For example: Leukemia, AIDS, HIV Infection, Radiotherapy, or Chemotherapy
- 13. Have you ever had Hepatitis, Jaundice, or Liver Disease?
- 14. Do you have a bleeding disorder?
- 15. Have you ever been hospitalized for any illnesses or operations?
If yes, please explain. _____
- 16. Have you or a family member ever had an adverse reaction to a general anesthetic?
- 17. Do you bleed EXCESSIVELY from a cut or injury?
- 18. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD. Please .
 - chest pain lung disease
 - rheumatic fever diabetes cancer
 - pacemaker kidney disease drug/alcohol dependency
 - steroid therapy stomach ulcer malignant hyperthermia
 - seizures (epilepsy) liver disease emphysema
 - osteoporosis medications (e.g. Fosamax, Actonel) thyroid disease psychiatric illness
 - heart attack arthritis sickle cell disease
 - tuberculosis shortness of breath heart rhythm disorder
 - mitral valve prolapse heart murmur eating disorder
 - stroke gastrointestinal disorder

YES NO

- 19. Are there any conditions or diseases not listed above that you have or have had?
If so, what? _____
- 20. Are there any diseases or medical problems that run in your family?
(e.g. diabetes, cancer, or heart disease) _____
- 21. Do you smoke or chew tobacco products?
- 22. Are you nervous during dental treatments?
- 23. **FOR WOMEN ONLY:** Are you breastfeeding or pregnant? If pregnant, what is the
expected delivery date? _____

To the best of my knowledge, the above information is correct:

PATIENT/ PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

DOCTOR'S NOTES:

DOCTOR'S SIGNATURE _____ DATE: _____