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 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) (Prefers to be called)

Address: (#) (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: (#) (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
	☐ arthritis	☐ sickle cell disease
☐ heart attack	☐ shortness of breath	☐ heart rhythm disorder
☐ tuberculosis	☐ heart murmur	☐ eating disorder
☐ mitral valve prolapse		☐ gastrointestinal disorder
	☐ stroke	

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:

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DOCTOR'S SIGNATURE____________________ DATE: ________