PATIENT REGISTRATION

If you have dental insurance, please give your insurance information to the receptionist.

Patient's Name:

_____

(last) (first) (initial)

Address:

_____

(street)

_____

(city) (province) (postal code)

Date of Birth:

_____

Age: _____ **Gender:** _____ **Marital Status:** _____

Home Phone: _____

Cell Phone: _____

Family Medical Doctor: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name:

_____

(last) (first) (initial)

Relationship to Patient:

_____

Phone: _____

Whom may we thank for referring you?

_____

MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment.

ALL INFORMATION IS CONFIDENTIAL.

1. Have you ever had a serious illness requiring hospitalization or extensive medical care? If yes, please specify.

   ☐ YES ☐ NO

_____

2. Are you presently under the care of a medical professional? If yes, please specify.

   ☐ YES ☐ NO

_____

3. Have you been hospitalized in the last two years?

   ☐ YES ☐ NO

4. Do you use any prescription or non-prescription medicine, including herbal remedies, regularly? If yes, please specify including dosage.

   ☐ YES ☐ NO

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5. Have you ever experienced an unusual or allergic reaction to any of the following? (please circle)

metal	latex	local anesthesia (freezing)	aspirin
penicillin	other _____		

6. Do you have or have you ever had any of the following? (please circle)

heart murmur	heart condition	heart attack	cancer
joint replacement	high/low pressure	seizures	radiation/chemotherapy
asthma	diabetes	liver disease	stroke
hepatitis A/B	mental or nervous disorder	autoimmune disorder	sinus trouble
migraines	HIV/AIDS	kidney disease	arthritis
anemia	stomach/intestinal problems	other _____	

7. Do you bruise easily or bleed abnormally?

   ☐ YES ☐ NO

8. Do you smoke? If so, how often?

   ☐ YES ☐ NO

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9. **WOMEN ONLY:** Are you pregnant?

   ☐ YES ☐ NO Due Date: _____

DENTAL HISTORY

1. When was your last dental visit? _____
2. If different, when was your last dental cleaning? _____
3. When did you last have x-rays taken? _____
4. Are any of your teeth sensitive to:

   ☐ Cold ☐ Sweets ☐ Heat ☐ Other _____

5. Do your gums bleed when:

   ☐ Brushing ☐ Flossing ☐ Spontaneously

6. Have you ever had any of the following? (please circle)

oral surgery	orthodontic treatment	bite plate
periodontal treatment	wisdom teeth removal	root canal

7. Do you suffer from any pain or swelling of your gums?

   ☐ YES ☐ NO

8. Do you have any jaw troubles (clenching, popping, limited joint opening)?

   ☐ YES ☐ NO

9. Do you gag easily?

   ☐ YES ☐ NO

10. Are you concerned about the appearance of your teeth? If so, what would you like to see changed?

    ☐ YES ☐ NO

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11. Brushing: ☐ Vigorous ☐Light How often? _____

12. Other cleaning aids used: ☐ Floss ☐Toothpick ☐Electric Toothbrush

I, the undersigned, certify that all medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my physician being contacted if necessary, as this information may be required for my dental care.

_____ _____

(signature) (print name)

Date: _____