

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Full Name: Date of Birth: Sex:
Marital Status: Driver's License / S.I.N #: Age:
Address: City: Province:
Postal Code: Country:
Email: Home Phone: Mobile:
Family Doctor: Family Doctor's Contact Number:
Emergency Contact: Emergency Contact's Number:

How did you hear about us?

RESPONSIBLE PARTY

Self Other (If other, please fill in information below)

Full Name: Date of Birth: Sex:
Marital Status: Driver's License / S.I.N #: Age:
Address: City: Province:
Postal Code: Country:
Email: Home Phone: Mobile:

MEDICAL HISTORY

Are you presently under the care of a physician?

Have you had any serious illnesses, operations, or hospitalization?

Are you currently taking any medication?

Have you ever taken anti-obesity medication (weight loss drugs)?

Do you bruise easily or have prolonged bleeding?

Do you smoke or chew tobacco? How much per day?

Have you ever fainted, had shortness of breath or chest pain?

Any fever or chills within the last 24 hours?

Any recent exposure to infectious disease? (chicken pox, measles, etc.)



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Any history of joint prosthesis procedures in the past 2 years?

Any family history of Prion Disease, or symptoms that may be indicative of CID, such as sudden onset of dementia?

Recently travelled? Where?

Immunization History?

Are you pregnant? (For female patient only) Yes No

Are you nursing? (For female patient only) Yes No

Are you taking birth control pills? (For female patient only) Yes No

Do you have allergies of the following?

Aspirin	Barbiturates	Codeine	Sulda Drugs	Iodine	Latex
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Local Anesthetic	Antibiotics	Other
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Do you have or have you ever had the following?

Anemia	Angina	Anorexia	Artifical Heart Values	Arthritis/Rheumatism
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Artifical Replacements	Asthma	Back Problems	Blood Disease	Bronchitis
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Bulimia	Cancer	Chest Pains	Chronic Diarrhea	Chronic Fatigue
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Circulation Problems	Cough, Persistent	Cortisone	Diabetes	Depression/Anxiety
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Emphysema	Epilepsy	Fainting/Dizziness	Frequently Tired	Glaucoma
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Hay Fever	Head/Neck Injuries	Heart Attack/Disease	Heart Murmurs
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Heart Problems	Hemophilia	Hepatitis A	Hepatitis B	Hepatitis C	Hepatitis D
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Hepatitis E	Herpes	High Blood Pressure	HIV / AIDS	Hypoglycemia	Jaundice
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Kidney Disease	Leukemia	Liver Disease	Lung Disease	Mental Disorder
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Mitral Valve Prolapse	Organ Transplant	Pacemaker	Radiation Therapy
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Recent Weight Loss	Respiratory Disease	Rheumatic/Scarlet Fever
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Sexually Transmitted Disease	Shortness of Breath	Sinus Problems	Skin Rash
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Stomach Problems	Stroke	Swollen Ankles	Thyroid Problems	Tonsillitis
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Tuberculosis	Ulcers	Venereal Disease	Other
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PATIENT REGISTRATION FORM

DENTAL HISTORY

What is the reason for today's visit?

How frequently do you see a dentist?

Date of last dental cleaning?

Date of last X-Rays?

Previous Dentist?

How often do you brush per day? Do you use floss?

Do you use anti-bacterial rinse?

Are your teeth sensitive to: Hot Cold Sweets Other

Do your gums bleed when: Brushing Flossing Sweets

Do your gums feel swollen or tender?

Does your breath concern you?

Do you have any jaw/joint problems?

Do you grind or clench your teeth?

Do you get frequent headaches?

Does food get caught between your teeth?

Have you ever had a problem with local anaesthetic (freezing)?

Have you ever had any problems with previous dental treatments?

Is there anything else that we should know about your health?

Are you satisfied with the appearance of your teeth?

Are you fearful of dental treatments? What triggers your fear?

CONSENT FOR TREATMENT

I hereby certify that the information in the medical and dental histories is accurate and complete to the best of my knowledge. I authorize the release of medical information from my medical doctor or health care provider as is required by this dental office. I consent to the dental procedures agreed to be necessary or advisable for myself and my child, including the use of local anaesthetic, or other drugs as indicated. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered for both myself and my dependents.

Patient Name

Patient/Parent Signature

Date

