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REGISTRATION & HEALTH HISTORY

Patient's Name: Mr. Dr. Mrs. Ms. Miss ____ Date Of Birth:______________________
(month/day/year)

Home Address:____ City:________________________ Postal Code:_________________
Home Phone # __________________________Cell Number: ____________________ Email:_________________________________
we collect your email for appointment confirmation purposes only. Please provide us with your email if you wish to confirm your appointment using email

Employer:___________________________________ Occupation:________________________ Business Phone#_____________________

Spouse's Name:_______________________________ Employer:_________________________Business Phone#_____________________

Whom may we thank for referring you? ____

Do You Have Dental Insurance? Yes □ No □ Name of Person Responsible for This Account __________________
Do Any Other Family Members Attend This Practice? Yes □ No □
Family Physician_________________________ Phone #__________________
Previous Dentist_________________________ Phone# __________________
Reason for Appointment / Examination ____
Specific Problem Area____

MEDICAL HISTORY:

(Women Only) Please Let Us Know If You Are Pregnant / Breast Feeding Yes □ No □
Aside From Regular Check Ups, Are You Presently Under The Care Of A Physician? Yes □ No □ Date Of Last Physical _____________________
(day/month/year)

DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (please check & give details where indicated)

☐ Injury to head/neck areas______________________________
☐ Heart Condition / Pace Maker __________________________
☐ Heart Murmur / Mitral Valve Prolapse ____________________
☐ Stroke ____
☐ Liver Problems______________________________________
☐ Hepatitis – Type A or B or C or Unknown __________________
☐ Arthritis or Joint Problems ____________________________
☐ Tuberculosis _______________________________________
☐ Thyroid Trouble ____________________________________
☐ Kidney Trouble _____________________________________
☐ Healing Complications _______________________________
☐ Rheumatic Fever____________________________________
☐ **Drug Allergies or Drug Reactions List:**
☐ Allergies/ Sensitivity to Foods/Metals/Latex?
____

☐ Stomach or Intestinal Problems (Ulcer) ___________________________
☐ Artificial Joints or Implants ____________________________________
☐ Artificial Heart Valves ____
☐ Asthma / Breathing Problem ____________________________________
☐ Cancer (Tumour / Malignancies)__________________________________
☐ Diabetes ____
☐ Malignant Hyperthermia ____
☐ Excessive Bleeding or Blood Related Disorders______________________
☐ Immune Deficiency, Aids Related Complex or A Positive Blood Test for HTL-111 Virus ____
☐ Mental / Nervous Problems or Psychiatric Care ______________________
☐ Epilepsy ____

Do you Have A family History of:
Diabetes: □ Yes □ No
Heart Problems: □ Yes □ No
Bleeding Problems: □ Yes □ No

Have You Ever Been Hospitalized For Any Surgeries? Yes □ No □ Reason:____

Please List All Current Medications, Prescribed or Self-Administered, or Herbal Supplements:

____
____

Please List Current Medical Treatment you Are Undergoing, Impending Operations or Any Other Medical or Dental Information That May Possibly Affect Your Dental Treatment:

____
____

Have you ever been advised by your Doctor to take antibiotics before dental treatment? Yes □ No □

DENTAL HISTORY:

When was your last Dental Visit? ______________________________ (day/month/year) What was it for?____

How often did you visit a dentist before that time? ________________ Last X-Rays taken? _________________________________ (day/month/year)

Are you having any discomfort at this time? Yes □ No □ Where? ____

How long has this been a concern? ____

Are your teeth sensitive to: □ heat___________________ □ cold_________________ □ sweet_________________ □ pressure_______________

Are you aware of any swollen areas or sores in your mouth? Yes □ No □ Where:

____

Have you lost any teeth? Yes □ No □ Why? ____

Any complications with the extractions? Yes □ No □ Have they been replaced by a: □ Fixed Bridge □ Full Denture □ Partial Denture □ Implants

Have you undergone orthodontic treatment at any time? Yes □ No □ At What Age: _________

Do you smoke/chew tobacco products? Yes □ No □ At what age did you begin smoking: __________ quantity per day?______________

Do you use a transdermal nicotine patch? Yes □ No □

Do you have bad breath or an unpleasant taste in your mouth? Yes □ No □

How often do you brush your teeth? _______ Do you regularly use: Dental Floss : Yes □ No □

Do your gums bleed Yes □ No □ When?_______________________________ Where? ____

Do you clench or grind your teeth? Yes □ No □ Do you have any loose teeth? Yes □ No □ Where? ____________________________________

Have you ever been told that you have a gum problem? Yes □ No □

Have you ever had gum treatment? Yes □ No □ When? ____

Have you ever had any pain in or around your ears? Yes □ No □

Have you ever had any clicking, popping or snapping noises when you chew? Yes □ No □

Do you have any nasal obstruction? Yes □ No □

Do you have, or have you had in the past, any disease, condition or problem not listed?

____

What are your expectations of what we may provide for your dental health?

____

Authorization & Release

I certify that I have read and understand the above information. The above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize the qualified dental personnel in this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or diagnostic procedures.

Signature: ___________________________________ (Patient Parent / Guardian) Print Name:_______________________________________ Date:_______________________ (day/month/year)