

Registration Form

Name _____ Birthdate _____
Address _____
City _____ Province: _____ Postal code: _____
Phone: _____ Email: _____
Would you like email or text reminders? ☐ YES ☐ NO
Person to contact in case of emergency _____
Check appropriate box ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated

Patient or Parent/Guardian's Employer _____
Address _____
City _____ Province _____ Postal code _____
Contact #: _____
Patient is a student, name of school or college _____
City _____ Province _____ Student# _____

How did you hear about our office? _____

****If under the age of 18 yrs old – Please have parent/Guardian complete below***

Relationship to patient _____
Birthdate _____
Address _____ Home
phone _____
E-mail _____ Cell phone _____
Driver's License _____
Employer _____ Workphone _____

Primary Insurance Information:

Name of insured _____
Insurance Company _____ Group # _____ Certificate# _____
Date of birth _____ SIN# _____
Name of employer _____ Work phone _____

Secondary Insurance information:

Name of insured _____
Insurance Company _____ Group # _____ Certificate# _____
Date of birth _____ SIN# _____
Name of employer _____ Work phone _____

Patient name _____ Date of birth _____

Dental History

Do you at present time have any dental complaints _____ ☐ YES ☐ NO
Any hot or cold sensitivity in your mouth _____ ☐ YES ☐ NO
When was your last X-rays taken? Where _____ ☐ YES ☐ NO
Have you experienced any growth or sore spots in your mouth? If yes, please locate _____ ☐ YES ☐ NO
Do your gums bleed _____ ☐ YES ☐ NO
Have you experienced any of following jaw problem: Popping/ locking in your jaw join ☐ YES ☐ NO
Pain near your ears? _____ ☐ YES ☐ NO
Difficulty opening or closing? _____ ☐ YES ☐ NO
Do you grind or clench your teeth? _____ ☐ YES ☐ NO
Have you had any following:
Periodontal treatment YES ☐ NO
Ortho Treatment ☐ YES ☐ NO
Oral/jaw surgery ☐ YES ☐ NO
Are you unhappy with the appearance of your teeth?
If so, what would you like to see changed ☐ YES ☐ NO?

Although dental personnel primary treats the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication that you may be taking could have an important in relationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now? ☐ Yes ☐ No if yes please explain _____
Have ever been hospitalized or major surgery? ☐ Yes ☐ No if yes please explain _____
Have you ever had serious head or neck injury? ☐ Yes ☐ No if yes please explain _____
Are you taking any medications, pills or drugs? ☐ Yes ☐ No if yes please explain _____
Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No if yes please explain _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications contain bisphosphonates?
☐ Yes ☐ No if yes please explain _____
Are you on a special diet? ☐ Yes ☐ No if yes please explain _____
Do you use tobacco? ☐ Yes ☐ No if yes please explain _____
Do you use controlled substances? ☐ Yes ☐ No if yes please explain _____
Are you Pregnant/Trying to get Pregnant?
☐ Yes ☐ No Taking Oral Contraceptives ☐ Yes ☐ No Nursing ☐ Yes ☐ No
Are you allergic to following?

☐ Aspirin ☐ Penicillin ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulpha Drugs
☐ Other If yes please explain _____

Do you have, or have you had any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Alzheimer disease	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Fainting spells	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Renal Disease	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Breathing problems	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Cortisone Medication	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tuberculous	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Easily Winded	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Epilepsy/Seizures	☐ Yes ☐ No	Low Blood Sugar	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No

Pharmacy name & phone number _____

List of medications:

Patient Name

Patient Signature

Date

Dentist Signature

Date