



Welcome To Our Dental Office!!

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. We are happy to assist you with the completion of this form. Thank you for your confidence in our office. **Please print.**

REGISTRATION INFORMATION

The patient is an: Adult Child Adult under guardianship Name of guardian:

Name: (first) (last) (initial) Dr. Mr. Mrs. Ms. Miss

Address: (street) (apt.#) (city) (province) (postal code)

Home Phone: Cell Phone: E-Mail:

Bus. Phone: (ext.) Employer:

Driver's License Number: S.I.N.:

PERSONAL INFORMATION

Prefers to be called:

Date of Birth: (Day / Month / Year) Male Female Single Married Spouse:

Are other family members patients at our office? No Yes Names:

Whom may we thank for referring you?

MEDICAL INFORMATION

Family Physician: Phone:

Medical Specialist: (if presently under the care of) Phone:

In case of emergency, please contact: Phone:

Nearest relative not living with you: Phone:

FINANCIAL INFORMATION

Responsibility for account: Self Spouse Other Please complete below **ONLY** if different than above.

Name: (first) (last) (initial) Home Phone:

Address: (street) (apt.#) (city) (province) (postal code)

Employed by: Business Phone: (ext.)

Driver's License Number: S.I.N.:

PRIMARY DENTAL INSURANCE

Subscribers Name: (Date of birth)

Ins. Co.

Grp. Policy #

I.D. #/Certificate #

% Coverage: Basic Major Ortho

Deductible: Insurance Year end:

Annual Maximum \$: (Basic) (Major) (Perio)

SECONDARY DENTAL INSURANCE

Subscribers Name: (Date of birth)

Ins. Co.

Grp. Policy #

I.D. #/Certificate #

% Coverage: Basic Major Ortho

Deductible: Insurance Year end:

Annual Maximum \$: (Basic) (Major) (Perio)

Thank you!

.....Over

MEDICAL HISTORY

Please answer or ✓ Yes or No to each question. If unsure of a question, please consult with the dentist.

YES NO

When was your last dental exam and cleaning?

Have you been a patient in the hospital during the past two years?

Are you taking any medications? If yes, please list names and for what they are taken:

Medication: _____	Taken for: _____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever reacted adversely to any of the following (if yes, please circle):

Antibiotics Codeine Dental Freezing Latex

Are you allergic or have you reacted adversely to any other medications or substances?

If yes, please list:

Have you ever been advised against taking any specific type of medication

Please circle any of the following that you have had or have at present:

A.I.D.S./H.I.V.	Blood disorders	Kidney Disease	Fainting or dizzy spells
Anemia	Bruise easily	Glaucoma	Heart disease or attack
Angina Pectoris	Cold Sores	Liver Disease	Mitral Valve Prolapse
Arthritis/Rheumatism	Sinus Trouble	Heart Murmur	Rheumatic/Scarlet Fever
Artificial heart valve	Diabetes	Heart pacemaker	Congenital heart lesions
Artificial joints	Emphysema	Hepatitis A B or C	Stomach/intestinal problems/Ulcers
Asthma	Epilepsy or seizures	Stroke	High/Low Blood Pressure

Do you drink more than 4 cups/cans of coffee, tea, pop, juice or other beverage per day?

Are you on a special diet?

Do you have frequent headaches?

Do you smoke?

Women Only: Are you pregnant?

Taking birth control or hormone replacement?

Has any family member had diabetes?

Do you bleed **excessively** from a cut or injury or bruise easily?

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

Is there anything else about your health we should be made aware of?

I, the undersigned, certify that I have provided an accurate and complete personal and medical/dental history. I understand that providing incorrect information can be dangerous to my health. Should there be any change in my health status in the future, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I authorize the dentist to release any information, including the diagnosis and records of any treatment rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners. ***I understand that the responsibility for payment of the dental services for myself and my dependents is mine and due and payable at the time of service unless other financial arrangements have been made.***

X _____

Signature: Patient Parent Guardian

_____ Print name of guardian

_____ Date

_____ Dr. Sig

Thank you for your time!!