

PATIENT REGISTRATION

NAME (Please Write Above)		HOME PHONE	CELL	EMAIL
RESIDENCE ADDRESS			CITY	POSTAL CODE
EMERGENCY CONTACT	RELATIONSHIP	BUSINESS PHONE	HOME PHONE	CELL PHONE
EMPLOYED BY	OCCUPATION		PHONE	
PRIMARY INSURANCE CARRIER	GROUP POLICY #	SUBSCRIBER ID #	SUBSCRIBER'S DATE OF BIRTH	
SPOUSE EMPLOYED BY	OCCUPATION		PHONE	
SECONDARY INSURANCE CARRIER	GROUP POLICY #	SUBSCRIBER ID #	SUBSCRIBER'S DATE OF BIRTH	

HOW DID YOU HEAR ABOUT OUR OFFICE?

MEDICAL HISTORY

BIRTHDATE _____ AGE _____

PHYSICIAN'S NAME _____ Date of last physical exam _____

Were you recently seen by a physician? Yes No If yes, for what reason? _____

Have you recently visited a hospital? Yes No If yes, when and for what reason? _____

Are you taking any medication at this time? Yes No If yes, please list all medications _____

Do you currently have or have previously had any of the following? Please indicate with a check mark (✓)

- | | | | |
|-----------------------------------------------|--------------------------------------------------|-----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Are you pregnant? | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Malignancies/Cancer | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Any Heart Conditions | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Do you use inhalers? | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> AIDS / HIV Infection | <input type="checkbox"/> Do you smoke? |
| | | | <input type="checkbox"/> Eating Disorder |

Do you have allergies? If yes, please list. _____

Please note any additional medical information _____

DENTAL HISTORY

Are you having any discomfort at this time? _____ If yes, please explain _____

How long since you've seen a dentist? _____ Any complications with extractions? _____

Do you have any?: (1) Fixed Bridges _____ (2) Removable Partial _____ (3) Denture _____

When were they made? _____ Are your teeth sensitive to: Heat / Cold / Sweets / to Biting? (circle)

How often do you brush your teeth? _____ How often do you use Dental floss? _____

Do your gums bleed? _____ Does food wedge between your teeth? _____ Do you grind or clench your teeth? _____ When? _____ Do you feel you have bad breath? _____ An unpleasant taste in your mouth? _____ Any pain in or around your ears? _____ Do you have popping, clicking or snapping noises when you chew? _____ Are you aware of any swelling or lump in your mouth/ head / neck? _____

Are you anxious about having dental treatment? _____ If yes; why? _____

Do you feel you require or want something to relax you during treatments? _____

Are you eager to keep your teeth and avoid dentures? _____

Please note any additional DENTAL information _____

Payment is due on the date that service is rendered.

Your appointment times are reserved especially for you. If unable to keep your reservation, **PLEASE give 2 business days notice** so that another patient may use your time. There will be a charge for time lost when the required notice has not been given.

DATE

PATIENT or GUARDIAN'S SIGNATURE