WELCOME TO OUR OFFICE

PATIENT REGISTRATION & HEALTH HISTORY *MEDICAL ALERT*

Last Name:	First:	Birthdate:	☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss
Address:		City:	Province:
Postal Code:	Home #( )	Work #( )	Cell #( )
Email:		Referred By:	
Employer:	Phone#:		
In case of an emergency please notify:		Phone#:	

Health History:

1. Have you had a medical examination in the last year?----------Yes / No
2. Have you been a patient in the hospital during the past two years?----------Yes / No
3. Please state your physician's name: _____ Phone: _____
4. Please list all the medications you are on now: _____
   _____
5. For WOMEN only: Are you pregnant? YES / NO If yes, what month_____
6. Are you taking birth control pills? YES / NO

Are you allergic or have you reacted to any of the following medications? Please circle which ones:

Acetaminophen (Tylenol)	Demerol	Nitrous Oxide	Sulfa
Aspirin	Diazepam (Valium)	Penicillin	Triazolam (Halcion)
Codeine	Erythromycin	Percocet	Other Antibiotics
Clindamycin	Lorazepam (Ativan)	Sleeping pills	Latex

Are you aware of being allergic to any other medications or substances?----------YES / NO

Circle all of the following which you have:

AIDS	Congenital Heart Lesions	Heart Pacemaker	Organ Transplant
Allergies/Hives	Cortisone/Steri eroid	Heart Surgery	Psychiatric Disorders
Angina Pectoris	Diabetes	Hemophilia	Radiation/Chemotherapy
Anemia	Drug Addiction	Hepatitis A/B/C	Sickle Cell Disorder
Artificial Heart Valve	Emphysema	Herpes	Sinus Trouble
Artificial Joints	Epilepsy/Seizures	High/Low Blood Pressure	Stomach Problems
Arthritis/Rheumatism	Fainting/Dizzy Spells	HIV Positive	Stroke
Asthma	Fever Blisters	Infective Endocarditis (EI)	Thyroid Disease
Blood Disorders	Glaucoma	Kidney Trouble	Tuberculosis (TB)
Bruise Easily	Hay Fever	Liver Disease	Ulcers
Cancer	Heart Disease/Attack	Lung Disease	Venereal Disease
Cold Sores	Heart Failure/Murmur	Mitral Valve Prolapse	Yellow Jaundice

If you have any disease, condition or problem not mentioned above, please list:

Dental History:

1. Have you had regular dental exams in the past? YES / NO
2. When was your last dental visit? _____
3. What was done? _____
4. Have you ever had abnormal bleeding or other problems associated with previous dental extractions or surgery? YES / NO
5. Are you having dental discomfort? YES / NO
6. Are you having dental pain? YES / NO
7. Are you happy with the appearance of your teeth? YES / NO
8. Do you have any oral habits such as clenching or grinding, nail biting or sucking your thumb? YES / NO
9. Have you had dental x-rays taken in the last year? YES / NO
10. Have you ever had professional tooth brushing and flossing instruction? YES / NO
11. I brush _____ times a day
12. I floss _____ times a day
13. My gums bleed: never sometimes often
14. I am interested in sedation: YES / NO
15. Have you had any problems with or unpleasant reactions to dental treatment? YES / NO
16. My primary concern is: _____
    _____
    _____

Consent

1. I certify that the above information is correct to the best of my knowledge.
2. I authorize the doctor upon consultation and direct consent from the patient/parent/guardian to perform diagnostic procedures, treatment and medication in the connection with the patients dental needs.
3. I understand that responsibility for payment of dental services, including insurance or otherwise, is due and payable at the time services is rendered and despite any dental insurance, I am ultimately responsible for any fees withheld by the insurance company.

Date: _____ Signature: _____ Patient( ) Parent( ) Guardian( )

(please mark "X" which one applies)

What brought you in today? Are you experiencing any pain or have any specific concerns?

_____

_____

If you could change just one thing about your <u>front teeth</u>, those we see when you smile:

What would that be?

_____

_____

- How do you feel about the color of your front teeth, are they white enough? ☐ No ☐ Yes
- Do you like the way they are shaped? ☐ No ☐ Yes
- Are your front teeth as straight as you'd like them to be? ☐ No ☐ Yes
- Are you satisfied with their overall appearance? ☐ No ☐ Yes
- Is there anything you'd like to change about them? ☐ No ☐ Yes

Now let's talk about your back teeth, the ones you chew on:

- If there was anything you could change about these, What would it be? _____
- Do you have any sensitivity to hot or cold or when you chew? ☐ No ☐ Yes
- Do you have difficulty chewing? ☐ No ☐ Yes
- Are you missing any teeth? ☐ No ☐ Yes
- Does food get trapped and annoy you? ☐ No ☐ Yes
- Is there anything in the back that you'd like us to look at?

_____

_____

Your <u>gums</u> aren't something most people think about, but let me ask you this:

- Do your gums ever bleed? ☐ No ☐ Yes
- Do you ever experience any sensitivity? ☐ No ☐ Yes
- How is your breath? _____
- Do you have any recession? ☐ No ☐ Yes
- Do you have removable dentures/partials in your mouth? ☐ Yes ☐ No
- Are they comfortable? ☐ No ☐ Yes