

PATIENT REGISTRATION

Patient name _____ Date of birth (d/m/y) _____

Mailing address _____

Phone # _____ Email _____
home mobile

Emergency contact name & phone # _____

Name of person responsible for account _____

Health card # _____ Expiry date (d/m/y) _____

Primary Insurance Coverage

Do you have dental insurance? yes no

Insurance company _____ Employer _____

Policyholder name _____ Policyholder DOB (d/m/y) _____

Group/Contract/Policy# _____ Employee # _____

Secondary Insurance Coverage

Do you have secondary dental insurance? yes no

Insurance company _____ Employer _____

Policyholder name _____ Policyholder DOB (d/m/y) _____

Group/Contract/Policy# _____ Employee # _____

How did you hear about us? My dentist Internet Other _____

Patient's (or Guardian's) Signature: _____

Date: _____

MEDICAL HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS ACCURATELY. YOUR RESPONSES WILL REMAIN STRICTLY CONFIDENTIAL.			
		Yes	No
1.	Are you under the care of a physician for any medical conditions?		
2.	Have you had an annual check-up within the past 12 months?		
3.	Physician's name _____ Physician's phone number _____		
4.	Have you been hospitalized in the past 2 years?		
5.	Are you currently taking any medications prescribed by your physician? If yes, please list them below: _____ _____ _____		
6.	Are you allergic to any of these medications? <div style="display: flex; align-items: flex-start;"> <div style="flex: 1;"></div> <ul style="list-style-type: none"> <input type="radio"/> Penicillin <input type="radio"/> Sulfa drugs <input type="radio"/> Codeine <input type="radio"/> Aspirin <input type="radio"/> Iodine <input type="radio"/> Local anesthetics <input type="radio"/> Other: _____ </div>		
7.	Have you experienced excessive bleeding or bruising from a cut before?		
8.	Do you smoke? If yes, how much and for how long? _____		
9.	Do you use recreational drugs? If yes, how often and for how long? _____		

10.	Do you have any of the following conditions?	Yes	No		Yes	No
	AIDS			High blood pressure		
	Anemia			Jaundice		
	Angina pectoris			Kidney disease		
	Arthritis			Liver disease		
	Artificial heart valves			Malignant hyperthermia		
	Artificial joints (hip/knee)			Mental disorders (specify)		
	Asthma			_____		
	Bronchitis			Mitral valve prolapse		
	Cancer (specify)			Organ transplant (specify)		
	_____			_____		
	Diabetes (specify)			Radiation/ chemotherapy		

	Emphysema/bronchitis			Rheumatic/scarlet fever		
	Epilepsy/ seizures			Sickle cell disease		
	Glaucoma			Sinus trouble		
	Heart disease/ attack			Stomach/ intestinal problems		
	Heart murmur			Stroke		
	Heart pacemaker			Thyroid disease (specify)		

	Heart surgery			Tuberculosis		
	Hepatitis (A, B, or C)			Venereal disease		
	Herpes			Other: _____		
11.	Is there anything else about your health we need to know? _____					
WOMEN ONLY						
12.	Are you taking birth control pills?					
13.	Are you pregnant? If yes, how far along? _____					

