

Date _____

WELCOME TO OUR OFFICE

REGISTRATION INFORMATION

MEDICAL ALERT	
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The information that is requested on this Questionnaire is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly. **PLEASE PRINT.**

The patient is an: ADULT CHILD ADULT UNDER GUARDIANSHIP Name of Guardian: _____

Dr. Mr. Mrs. Ms. Miss Referred by: _____

Name: (last) _____ (first) _____ (initial) _____ (prefers to be called) _____ Birth Date: M. ___ D. ___ Y. ___

Address: (street) _____ (Apt.#) _____ (city) _____ (postal code) _____ Bus. Phone: () ___ - ___
Home Phone: () ___ - ___
Cell Phone: () ___ - ___

Age ___ Sex ___ Marital Status ___ May we call you at work? Yes No Employer: _____

Person responsible for account: _____ Name of Spouse: _____

Do you have insurance? Yes No Insurance Co. _____ Policy No. _____ Cert. No. _____

Driver's License No. (If required by office) _____ Social Insurance No. (If required by office) _____

Family Physician: (name) _____ (address) _____ Phone: () _____

Are you under the care of a Medical Specialist? Yes No _____ Phone: () _____

In case of emergency, please contact: _____ Phone: () _____

DENTAL HISTORY (Please Yes or No to each Question. If unsure of a question, please consult with the dentist.) YES NO

Is there a dental problem you would like treated immediately? Yes No Date of last dental cleaning: _____ visit: _____ X-rays _____

- Have you been seeing a dentist regularly? YES NO
- Have you ever had any of the following?
 - Periodontal treatment? (treatment of the gums) _____ YES NO
 - Orthodontic treatment? (to straighten or realign teeth) _____ YES NO
 - A bite plate or any other appliance? _____ YES NO
 - Your bite adjusted or teeth ground? _____ YES NO
 - Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?) _____ YES NO
- If you answered "yes" to the last question, who performed the surgery? _____ When was it done? _____
- Are you being followed up by a dental specialist? _____ YES NO
- Are there any growths or sore spots in your mouth? _____ YES NO
- Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? _____ YES NO
- Have you noticed any loose teeth, or, have any of your teeth shifted? _____ YES NO
- Does food catch between your teeth? _____ YES NO
- Are any of your teeth sensitive to heat, cold, sweets or pressure? _____ YES NO
- Have you been advised to take antibiotics before a dental appointment? _____ YES NO
- Do you use dental floss, proxabrush or stimulents? How often? _____ YES NO
- How often do you brush your teeth? _____ Do you feel that you have bad breath? _____ YES NO
- Have you ever experienced any of the following jaw problems:
 - Popping/clicking in your jaw joints? _____ YES NO
 - Pain in your jaw joints, around your ear, or side of your face? _____ YES NO
 - Difficulty in opening or closing? _____ YES NO
 - Pain when teeth are clenched? _____ YES NO
 - Pain or difficulty while chewing? _____ YES NO
- Do you have any of the following habits?
 - Clenching or grinding your teeth while awake or asleep? _____ YES NO
 - Biting your cheeks or lips? _____ YES NO
 - Mouth breathing while awake or asleep? _____ YES NO
 - Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? _____ YES NO
- Do you have any emotional concerns about having dental treatment? _____ YES NO
- Are you dissatisfied with the appearance of your teeth? _____ YES NO
or, What would you like to see changed? _____
- Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? _____ YES NO

(Complete both sides before signing) **GENERAL RELEASE**

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____ (PRINT NAME OF GUARDIAN)

PATIENT PARENT GUARDIAN

HEALTH HISTORY

Please YES or NO to each question. If unsure of a question, please consult with the dentist.

YES NO

1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: _____ Physician: _____ Phone: _____
2. Have you been hospitalized in the past two years? _____
3. When was your last visit to a Physician? _____ Last complete physical examination? _____
4. Have you recently, or are you presently, taking any **prescription** or **non-prescription** drugs incl. herbal remedies
 1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____
5. Have you ever reacted adversely to any medications or injections? (Please circle.) e.g. Penicillin, or other antibiotics aspirin, codeine, local anaesthetic (freezing), nitrous oxide, or any other medicine: _____
6. Have you ever been advised against taking any specific type of medication? _____
7. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions? _____
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain: _____
9. Is there a family history of Diabetes, Cancer or Heart Disease? _____
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? _____
11. Do your ankles, feet or hands swell? _____
12. Has your weight, appetite or energy level changed dramatically recently? _____
13. Do you follow a special diet, or are you on a diet pill therapy? _____
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? _____
15. Have you tested HIV positive? _____
16. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? _____
17. Have you ever had any injury or surgery to your face or jaws? _____
18. Do you wear eyeglasses or contact lenses? _____
19. Do you have any hearing difficulties? _____
20. Do you smoke or use any other forms of tobacco? _____
 Are you wearing the transdermal nicotine patch? _____
21. Are you alcohol and/or drug dependent? _____
 and, Have you received treatment? _____
22. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

	YES	NO		YES	NO		YES	NO
A.I.D.S.	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Head/neck injuries	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>
Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or attack	<input type="checkbox"/>	<input type="checkbox"/>	Mental/nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant/medical implant	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints(hip, knee)	<input type="checkbox"/>	<input type="checkbox"/>	Heart rhythm disorder	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment/chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A B C _____	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever → Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>
Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	High/Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart lesions	<input type="checkbox"/>	<input type="checkbox"/>	Hodgkins disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/intestinal problems/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroid	<input type="checkbox"/>	<input type="checkbox"/>	Hyper (Hypo) Glycemia	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Glandular disorders	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

23. Has the CHILD PATIENT recently had any of the following: (indicate approximate date.)
 Measles _____ Mumps _____ Chicken Pox _____
 Strep throat _____ Tonsillitis _____

24. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? _____
 25. Is there anything else about your health we should be made aware of? _____
 26. Do you wish to speak privately to the Doctor about any problem or medical condition? _____

27. WOMEN ONLY: Are you pregnant or suspect you may be? _____ Expected delivery date? _____
 Are you breast feeding? _____ Are you taking any birth control pills? _____

NOTE: IT IS IMPORTANT THAT ANY CHANGE IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

Reviewed by Treating Dentist: _____ Date: _____