Date: _____

WELCOME TO OUR OFFICE
REGISTRATION INFORMATION

MEDICAL ALERT	

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.____

Bus. Phone: ( ) _____

Address: (street) (Apt.#) (city) (postal code) Home Phone: ( ) _____

Email: _____

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 ❑ Ins. Co. _____ Policy/Cert.# (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: ( )

Relationship: _____

HEALTH HISTORY

Please ✓ YES or NO to each question

	YES	NO
1. Are you being treated for any medical condition at present or within the past year? If yes, please explain _____	☐	☐
2. Has there been any change in your general health in the past year? _____	☐	☐
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? (including herbal remedies) If yes, please list: _____	☐	☐
5. Have you ever had any adverse or unusual reaction to any medications or injections? e.g. penicillin, or other antibiotics, aspirin, codeine, local anaesthetic ("dental freezing")? Please explain: _____	☐	☐
6. Have you ever been advised against taking any specific type of medication? _____	☐	☐
7. Do you have any allergies? e.g. hay fever, food allergies, latex/rubber or metal allergies? _____	☐	☐
8. Do you have epilepsy or seizures? _____	☐	☐
9. Have you ever fainted during dental or medical treatment? _____	☐	☐
10. Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders? Please explain: _____	☐	☐
11. Are you on any cortisone or steroid therapy, or, are you on a diet pill therapy? _____	☐	☐
12. Do you have any artificial joints? (hip, knee) _____	☐	☐
13. Have you ever been advised to take antibiotics before dental treatment? _____	☐	☐
14. Do you have, or have you ever had, any heart or blood pressure problems? (heart attack or stroke) Please explain? _____	☐	☐
15. Do you have a heart murmur, valve dysfunction (mitral valve prolapse or artificial heart valve) or have you ever had Rheumatic Fever? _____	☐	☐

MEDICAL HISTORY continued on reverse side

HEALTH HISTORY continued

	YES	NO
16. Do you have or have you ever had any chest pain, shortness of breath or any heart palpitation without exertion?_____	☐	☐
17. Are you presently suffering from any infectious diseases? _____	☐	☐
18. Have you ever had Hepatitis, Jaundice or any Liver Disease? Please explain: _____	☐	☐
_____		
19. Do you have any condition that could affect your immune system? (e.g. arthritis, AIDS, HIV infection, lupus, inflammatory bowel disease, Crohn's disease?) Please specify: _____	☐	☐
20. Have you ever had any malignant disease, or are you presently undergoing any radiation treatment/chemotherapy?	☐	☐
_____		

21. Indicate which of the following you presently have, or ever had: **(Please Circle)**

Asthma	Tuberculosis	Glandular Disorders
Bronchitis	Diabetes	Organ Transplant/Medical Implant
Emphysema	Kidney Disease	Stomach/Intestinal Problems
Lung Disease	Thyroid Disease	Ulcers

22. Do you smoke?_____ Do you drink alcoholic beverages on a regular basis? _____ Use recreational drugs?_____	☐	☐
23. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer, heart disease) _____	☐	☐
24. Is there anything else about your health we should be made aware of; or do you wish to speak to the doctor privately about any problem or medical condition? _____	☐	☐
25. **WOMEN ONLY:** Are you taking birth control pills?_____ Are you breast feeding? _____ Are you pregnant? _____ Expected delivery date: _____		

DENTAL HISTORY

1. Is there a dental problem you would like treated immediately? Yes ❑ No ❑ _____		
_____		
2. Date of your last dental visit? _____ Last dental cleaning? _____ Last x-rays?_____		
3. How often do you brush your teeth?_____ Do you feel like you have bad breath: _____	☐	☐
4. Do you use dental floss? _____	☐	☐
5. Are your teeth sensitive to heat, cold or sweets? _____	☐	☐
6. Are you unhappy with the appearance of your teeth? _____	☐	☐
7. What would you like to see changed? _____		

PATIENT CONSENT

I hereby consent to the release of necessary information about my dental health situation to interested parties such as Insurance Companies, Dental Laboratories and other health care professionals. I understand that all personal information about me remains confidential and will not be divulged to 3rd parties unless it is necessary for my continuing dental health.
I authorize release, to my dental benefits plan administrator, and information contained in claim, submitted electronically.

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. 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.

I understand that I should provide the office with 48 hours notice to cancel or reschedule an appointment, otherwise a cancelation fee will apply.

X_____ _____

(signature) Patient ☐ Parent ☐ Guardian ☐ (print name of guardian)

Reviewed by Treating Dentist:_____ Date: _____