Patient Registration

All information is confidential

PATIENT: ____

First Name   Last Name   Preferred Name

Date of Birth (D/M/Y): ______________________ Age: _______ Sex: ________ Marital Status: ________

Address: __________________________City: _____________________ Postal Code: __________

Home Phone:____________________ Work Phone: ______________

Cell phone number for text message confirmations:______________

E-mail address for confirmations: ________________________________

If under 18 years of age, Parent or Guardian name: ____________________________________

First Name   Last Name   Date of Birth (D/M/Y)   Phone Number

Person to call in case of emergency: ____________________ Cell #: __________

First Name   Last Name

Whom may we thank for referring you? ____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important inter relationship with the dentistry that you will be receiving. Thank you for answering the following questions. **All information is confidential**.

1. When was your last medical exam?____________Physician's Name____________________

Are you presently under the care of a physician or have you been during the last 5 years? ☐ Yes ☐ No

If Yes, explain:____

2. Have you ever had a serious illness, accident requiring hospitalization or extensive medical care? ☐ Yes ☐ No

Specify:____

3. Do you use any prescription or non-prescription medicine (including birth control)? If so please list:

Drug ________________________ Reason______________________

Drug________________________ Reason______________________

Drug________________________ Reason______________________

4. Have you ever experienced any unusual reaction to any of the following? (please check)

☐ local anaesthesia ☐ sulfa drugs ☐ latex/rubber ☐ aspirin (ASA) ☐ erythromycin
☐ barbiturates ☐ penicillin ☐ metal (nickel) ☐ codeine ☐ other______________

Have you ever been warned against taking any drug or medication? ☐ Yes ☐ No If Yes, please specify__________

5. Do you have or have you ever had any of the following (Please check and or circle)

☐ arthritis or rheumatism
☐ asthma
☐ back problems
☐ cancer/radiation/chemo
☐ convulsions
☐ cortisone/steroid therapy
☐ diabetes
☐ drug/alcohol addiction
☐ epilepsy or seizures
☐ fainting or dizziness
☐ heart attack
☐ heart murmur/mitral valve prolapse
☐ herpes
☐ hepatitis A B or C
☐ HIV positive
☐ high low blood pressure
☐ hyper or hypo glycemia
☐ jaundice
☐ kidney/liver disease
☐ malignant hyperthermia
☐ mental or nervous disorder
☐ organ/medical implants
☐ scarlet or reheumatic fever
☐ sinus trouble
☐ stomach/intestinal problems
☐ stroke
☐ thyroid disease
☐ tumors
☐ other________

6. Do you have any blood disorders such as anemia? ☐ Yes ☐ No

7. Have you ever had any injury, surgery or x-ray therapy to your face or jaws? ☐ Yes ☐ No

If Yes, explain:____

8. Do you have frequent severe headaches? ☐ Yes ☐ No

9. Do you have any disease, condition or problem that you think the doctor should know about? ☐ Yes ☐ No

WOMEN ONLY Are you pregnant? ☐ Yes ☐ No If Yes, what month are you in?_______

PATIENT CONSENT AND APPROVAL

I have had the opportunity to ask and to receive answers or explanations regarding my medical/dental history. I, the undersigned, certify that all of the medical and dental information is true to my knowledge and I have not omitted any pertinent information. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary and consent to my physician being contacted if necessary.

Signature:______________________ Date:____________

day/month/year