

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: ( ) \_\_\_\_ - \_\_\_\_  
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 <input type="checkbox"/> No <input type="checkbox"/>	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 \_\_\_\_\_

PATIENT  PARENT  GUARDIAN  (PRINT NAME OF GUARDIAN) \_\_\_\_\_

# BLOOD THINNERS

## HEALTH HISTORY

## BONE STRENGTHENERS

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	
A.I.D.S.	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Lupus
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Head/neck injuries	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Hyperthermia
Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or attack	<input type="checkbox"/>	<input type="checkbox"/>	Mental/nervous disorder
Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant/medical implant
Artificial joints(hip, knee)	<input type="checkbox"/>	<input type="checkbox"/>	Heart rhythm disorder	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment/chemotherapy
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A B C _____	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever → Rheumatic fever
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease
Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	High/Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
Congenital heart lesions	<input type="checkbox"/>	<input type="checkbox"/>	Hodgkins disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/intestinal problems/Ulcers
Cortisone/steroid	<input type="checkbox"/>	<input type="checkbox"/>	Hyper (Hypo) Glycemia	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
Fainting or dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
Glandular disorders	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

23. Has the **CHILD PATIENT** recently had any of the following: (indicate approximate date.)

Measles _____	YES	NO	Strep throat _____
Mumps _____	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis _____
Chicken Pox _____	<input type="checkbox"/>	<input type="checkbox"/>	

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: \_\_\_\_\_