Welcome to the Practice

The following questionnaire will help us provide you with the highest standard of dental care. Please be assured that all information will remain confidential. We will happily assist you if you have any problems filling out this form.

REGISTRATION INFORMATION

Patient is an/a: ☐ Adult ☐ Child If Child – Name of Parent/Guardian:

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

(First Name) (Last Name) (Middle Initial) (Prefers to be called)

☐ Male ☐ Female Date of Birth: DD/MM/YYYY

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: (Street) (City) (Province) (Postal Code)

Home Phone: Work Phone: Other Phone:

Employer: Occupation:

What is the best phone number to use to contact you?

E-mail Address:

Are other family members, patients at our office? If yes, name:

How did you hear about us?

If you were referred, whom may we thank for referring you?

MEDICAL CONTACTS

Family physician:		Phone:	
In case of emergency, please contact:		Phone:	

FINANCIAL INFORMATION

Responsibility for account: ☐ Self ☐ Spouse ☐ Other

Please complete only if information is different from above:

Address: (Street) (City) (Province) (Postal Code)

Primary Dental Insurance		Secondary Dental Insurance	
Subscriber's Name:		Subscriber's Name:	
Subscriber's Date of Birth: DD/MM/YYYY		Subscriber's Date of Birth: DD/MM/YYYY	
Insurance Company:		Insurance Company:	
Group/Policy #:		Group/Policy #:	
I.D.#/Certificate #:		I.D.#/Certificate #:	

DENTAL INFORMATION

Are you having any pain or specific problems or concerns with your teeth?	☐ Yes	☐ No
Have you or do you have pain or discomfort in the jaw joint (TMJ/TMD)?	☐ Yes	☐ No
Do you drink more than 4 cups/cans of coffee, tea, pop, and/or juice per day?	☐ Yes	☐ No
Do you experience discomfort or bleeding with your gums?	☐ Yes	☐ No
Have you had any problems or difficulties with dental treatment in the past?	☐ Yes	☐ No
Do you feel nervous about receiving dental treatment?	☐ Yes	☐ No
Do you require antibiotics before dental treatment?	☐ Yes	☐ No
Do you snore or have you been diagnosed with sleep apnea?	☐ Yes	☐ No
Do you frequently breathe through your mouth instead of your nose?	☐ Yes	☐ No

MEDICAL INFORMATION

Have you recently been under the care of a physician?	☐ Yes	☐ No
Have you had a medical exam within the last year?	☐ Yes	☐ No
Have you been hospitalized or had any surgery done in the last two years?	☐ Yes	☐ No
Have you ever had a joint replacement (eg. hip, knee)? If so, when:	☐ Yes	☐ No
Have you had any serious injuries to the head, neck, or back?	☐ Yes	☐ No
Are you taking any prescription or non-prescription medications?	☐ Yes	☐ No

Name of Medication	What is it taken for

Have you ever had an adverse reaction to any of the following? (Please check the box and specify if needed):

Antibiotics ☐ Codeine ☐ Dental Freezing ☐ Latex ☐

Have you ever had an adverse reaction to any other medication or substance? If yes, please specify:	☐ Yes	☐ No
Have you ever been advised against taking a specific type of medication?	☐ Yes	☐ No

Please check the box below if you have or had any of the following conditions:

☐ A.I.D.S./H.I.V.	☐ Congenital Heart Lesions	☐ High Blood Pressure
☐ Alcohol or Drug Abuse	☐ Cold sores	☐ Kidney Disease
☐ Anemia	☐ Diabetes	☐ Liver Disease
☐ Arthritis	☐ Emphysema	☐ Low Blood Pressure
☐ Artificial heart valve	☐ Epilepsy/Seizures	☐ Mitral Valve Prolapse
☐ Asthma	☐ Fainting/Dizzy Spells	☐ Pacemaker
☐ Breathing problems	☐ Glaucoma	☐ Rheumatic/Scarlet Fever
☐ Blood disorders	☐ Heart Disease or Attack	☐ Stomach/Intestinal Problems
☐ Cancer	☐ Heart Murmur	☐ Stroke
☐ Chemotherapy or radiotherapy	☐ Hepatitis	☐ Thyroid Problems

Do you smoke? ☐ Yes ☐ No	If yes, for how many years?	How many packs per day?

Do you bleed excessively from a cut or injury or do you bruise easily?	☐ Yes	☐ No
Do you have or had any condition or problem not listed above?	☐ Yes	☐ No
Is there anything else about your health we should be made aware of?	☐ Yes	☐ No
For female patients: Are you pregnant or nursing?	☐ Yes	☐ No
Are you taking birth control pills or hormone replacement?	☐ Yes	☐ No

CONSENT FOR TREATMENT

I, the undersigned, certify that the information in this form is accurate to the best of my knowledge and that providing incorrect information can be dangerous to my or my child's health. Should my health status change, it is my responsibility to inform the dental office. I authorize the dental staff to perform any necessary dental services that are needed during diagnosis and treatment. I authorize the dentist to release any information, including the diagnosis and records of any treatment rendered to me or my child to third party payers and/or other health practitioners. I understand that the responsibility for payment of dental services for me and my dependents is mine and is due and payable at the time of service unless prior financial arrangements have been made.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE (DD/MM/YYYY)