Dr. Joe Simardone
Family Dental Care
creating beautiful smiles

CONFIDENTIAL PATIENT REGISTRATION

WELCOME TO OUR PRACTICE! WE LOOK FORWARD TO CARING FOR YOUR ORAL HEALTH.
The following information is required by our team to assist in proper diagnosis and treatment.

Today's Date: _____/_____/_____
month day year

PATIENT REGISTRATION

Prefer to be called (if different from below) _____ E-mail _____

Name: _____
(last) (first) (initial) Dr. __ Mr. __ Mrs. __ Ms __ Miss __

Address: _____
(street) (city) (province) (postal code)

Date of Birth: _____/_____/_____ Age _____ Sex _____ Marital Status _____ Home phone: ( ) _____
month day year

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

Medical Specialist: _____ Telephone: ( ) _____
(if currently under care) (name) (address)

Employer or School: _____ Telephone: ( ) _____ Ext. _____

Occupation: _____ In Case Of Emergency, please contact: _____
(name) (relationship)

PARENT or GUARDIAN REGISTRATION

Name: _____
(last) (first) (initial)

Address: _____
(if different from above) (street) (city) (province) (postal code)

Date of Birth: _____/_____/_____ Age _____ Sex _____ Marital Status _____ Home phone: ( ) _____
month day year

PERSON RESPONSIBLE FOR ACCOUNT:

Self _____ Other _____
(name) (relationship)

Address: _____
(if different from above) (street) (city) (province) (postal code)

Employer: _____ Telephone: ( ) _____ Ext. _____
(if different from above)

PRIMARY DENTAL INSURANCE: Yes ___ No ___ Subscriber's Name _____ Subscriber's Date of Birth _____/_____/_____
month day year

Insurance Carrier: _____Group Policy No. _____Certificate No. _____

SECONDARY INSURANCE: Yes ___ No___ Subscriber's Name _____ Subscriber's Date of Birth _____/_____/_____
month day year

Insurance Carrier: _____Group Policy No. _____Certificate No. _____

HOW DID YOU LEARN OF OUR PRACTICE? _____

Is another family member a patient in our practice? If so, who? _____

Reason for today's visit: Examination & cleaning _____ Emergency _____ Other _____

Do you have any specific questions or concerns? _____

_____

_____

MEDICAL HISTORY

The following information is required to enable us to provide the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. A team member will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

2. When was your last medical check-up?

3. Has there been any change in your general health in the past year? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
☐ YES ☐ NO ☐ NOT SURE/MAYBE

5. Do you have any allergies? If yes, please list using the categories below:
☐ YES ☐ NO ☐ NOT SURE/MAYBE
a) medications b) latex/rubber products c) other e.g. hay fever, foods

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE/MAYBE

7. Do you have or have you ever had asthma?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

11. Have you ever been advised by your doctor to take antibiotics before dental treatment?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

12. Do you have any condition or therapy that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy,chemotherapy?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

13. Have you ever had hepatitis, jaundice or liver disease?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

14. Do you have a bleeding problem or bleeding disorder?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

15. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE/MAYBE

16. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ shortness of breath	☐ cancer	☐ steroid therapy	☐ seizures (epilepsy)	☐ drug/alcohol dependency
☐ heart attack	☐ pacemaker	☐ lung disease	☐ diabetes	☐ kidney disease	
☐ stroke	☐ prosthetic heart valve	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	☐ diet pill therapy
		☐ arthritis			

17. Are there any conditions or diseases not listed above that you have or have had? Is so, what?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

18. Are there any diseases or medical problems that run in your family e.g. diabetes, cancer of heart disease?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

19. Do you smoke or chew tobacco products? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

20. Are you nervous during dental treatment? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

21. For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

To the best of my knowledge, the above information is correct and I agree to notify a team member of any change in my medical condition.

PATIENT/PARENT/ GUARDIAN SIGNATURE: _____ **DATE:** _____

DENTIST SIGNATURE: _____ **DATE:** _____

DENTAL HISTORY

1. When was your last dental visit?

☐ _____ months ago ☐ _____ years ago

2. How often do you get your teeth professionally cleaned?

☐ every _____ months ☐ rarely _____

3. Do you brush your teeth? If yes, how often?

☐ YES ☐ NO

4. Do you floss? If yes, how often?

☐ YES ☐ NO

5. Do you use a manual or an electric tooth brush?

☐ manual ☐ electric

6. Do any of your teeth hurt? If yes, please describe as upper/ lower, right side/ left side

☐ YES ☐ NO

7. Do your gums bleed or feel tender?

☐ YES ☐ NO

8. Do you grind or clench your teeth?

☐ YES ☐ NO

9. Do you wake-up with sore facial muscles or headaches?

☐ YES ☐ NO

10. Do you wear a mouth guard when playing sports?

☐ YES ☐ NO

11. Is there anything about your smile you like? If yes, please explain.

☐ YES ☐ NO

12. Is there anything about your smile you would like to change? If yes, please explain.

☐ YES ☐ NO

13. Are you happy with the colour of your teeth?

☐ YES ☐ NO

14. If no, would you like to improve the colour?

☐ YES ☐ NO

CREATING BEAUTIFUL SMILES: Your Comfort and Satisfaction is Our Priority

At Dr. Joe's, we are committed to ensuring your complete satisfaction with the dental care you receive. We will always thoroughly discuss your treatment plan and its cost with you and will answer any questions before treatment begins. We're pleased to offer dental technologies such as:

- digital radiography (x-rays) which reduces radiation exposure, is more environmentally friendly and is ready for viewing in seconds,
- intra-oral cameras to let you view the condition of your teeth and gums and make an informed decision about your treatment options,
- electronic dental insurance claim submission to speed up the claim process

At Dr. Joe's our team provides general dentistry for adults and children, as well as cosmetic dental services such as:

- Zoom 2® Chairside Tooth Whitening, and a variety of other whitening systems to suit your needs and your budget
- tooth-coloured porcelain veneers and crowns, often available in a single visit,
- tooth re-contouring and shaping,

PATIENT AUTHORIZATION
FOR ELECTRONIC CLAIM SUBMISSION

Patient's Name: _____
(last) (first) (initial)

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically .

This authorization shall continue in effect until the undersigned revokes the same.

_____ _____

Signature of patient, parent or guardian **Date**