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 ☐ No ☐ 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 _____		
1. Have you been seeing a dentist regularly? _____	☐	☐
2. Have you ever had any of the following?		
- Periodontal treatment? (treatment of the gums) _____	☐	☐
- Orthodontic treatment? (to straighten or realign teeth) _____	☐	☐
- A bite plate or any other appliance? _____	☐	☐
- Your bite adjusted or teeth ground? _____	☐	☐
- Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?) _____	☐	☐
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? _____	☐	☐
3. Are there any growths or sore spots in your mouth? _____	☐	☐
4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? _____	☐	☐
5. Have you noticed any loose teeth, or, have any of your teeth shifted? _____	☐	☐
6. Does food catch between your teeth? _____	☐	☐
7. Are any of your teeth sensitive to heat, cold, sweets or pressure? _____	☐	☐
8. Have you been advised to take antibiotics before a dental appointment? _____	☐	☐
9. Do you use dental floss, proxabrush or stimudents? How often? _____	☐	☐
10. How often do you brush your teeth? _____ Do you feel that you have bad breath? _____	☐	☐
11. Have you ever experienced any of the following jaw problems:		
- Popping/clicking in your jaw joints? _____	☐	☐
- Pain in your jaw joints, around your ear, or side of your face? _____	☐	☐
- Difficulty in opening or closing? _____	☐	☐
- Pain when teeth are clenched? _____	☐	☐
- Pain or difficulty while chewing? _____	☐	☐
12. Do you have any of the following habits?		
- Clenching or grinding your teeth while awake or asleep? _____	☐	☐
- Biting your cheeks or lips? _____	☐	☐
- Mouth breathing while awake or asleep? _____	☐	☐
- Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? _____	☐	☐
13. Do you have any emotional concerns about having dental treatment? _____	☐	☐
14. Are you dissatisfied with the appearance of your teeth? _____	☐	☐
or, What would you like to see changed? _____	☐	☐
15. 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? _____	☐	☐

(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)**

HEALTH HISTORY

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		YES	NO
A.I.D.S.	☐	☐	Glaucoma	☐	☐	Lupus	☐	☐
Anemia	☐	☐	Head/neck injuries	☐	☐	Malignant Hyperthermia	☐	☐
Angina pectoris	☐	☐	Heart disease or attack	☐	☐	Mental/nervous disorder	☐	☐
Arthritis/rheumatism	☐	☐	Heart murmur	☐	☐	Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐	Heart pacemaker	☐	☐	Organ transplant/medical implant	☐	☐
Artificial joints(hip, knee)	☐	☐	Heart rhythm disorder	☐	☐	Psychiatric treatment	☐	☐
Blood disorders	☐	☐	Heart surgery	☐	☐	Radiation treatment/chemotherapy	☐	☐
Bronchitis	☐	☐	Hepatitis A B C _____	☐	☐	Scarlet fever ⟶ Rheumatic fever	☐	☐
Cancer	☐	☐	Herpes	☐	☐	Sickle cell disease	☐	☐
Circulation problems	☐	☐	High/Low blood pressure	☐	☐	Sinus trouble	☐	☐
Congenital heart lesions	☐	☐	Hodgkins disease	☐	☐	Stomach/intestinal problems/Ulcers	☐	☐
Cortisone/steroid	☐	☐	Hyper (Hypo) Glycemia	☐	☐	Stroke	☐	☐
Crohn's disease	☐	☐	Hypertension	☐	☐	Thyroid disease	☐	☐
Diabetes	☐	☐	Inflammatory bowel disease	☐	☐	Tuberculosis	☐	☐
Emphysema	☐	☐	Jaundice	☐	☐	Venereal Disease	☐	☐
Epilepsy or seizures	☐	☐	Kidney disease	☐	☐	Other _____		
Fainting or dizzy spells	☐	☐	Liver disease	☐	☐	Other _____		
Glandular disorders	☐	☐	Lung disease	☐	☐	Other _____		

	YES	NO		YES	NO
23. Has the CHILD PATIENT recently had any of the following: (indicate approximate date.)					
Measles _____	☐	☐			
Mumps _____	☐	☐	Strep throat _____	☐	☐
Chicken Pox _____	☐	☐	Tonsillitis _____	☐	☐
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:** _____

FORM: DMD845REGC
REV:6