Welcome To Our Office

PATIENT REGISTRATION & HEALTH HISTORY *** MEDICAL ALERT***

Last Name: First: Birth Date: Female Male

Address:

City: Province: Postal Code:

Home Phone: Work Phone: Cell Phone:

Email: Whom may we thank for referring you?

Name of parent / guardian, if patient is under 18 years old:

Health History:

1. Have you had a medical examination in the last year? Yes No
2. Have you been a patient in the hospital during the past two years? Yes No
3. Please state your physician's name: Phone
4. Please list all the medications you are on now:

5. For WOMEN only: Are you pregnant? Yes No If yes, what month
6. Are you taking birth control pills? Yes No

Are you allergic or have you reacted to any of the following medications? Please Check off which ones:

Acetaminophen (Tylenol)	Demerol	Locazepam (Ativan)	Percocet
Aspirin	Diazepam (Valium)	Nitrous Oxide	Sleeping Pills
Codeine	Erythromycin	Novocain	Triazolam (Halcion)
Clindamycin	Local Anesthetic	Penicillin	Other Antibiotics

Antibiotics Are you aware of being allergic to any other medications or substances? Yes No

Check all of the following which you have:

AIDS	Congenital Heart Lesions	Heart Pacemaker	Psychiatric
Disorders Allergies/Hives	Cortisone/Steriod Meds	Heart Surgery	Radiation/Chemotherapy
Angine Pectoris	Diabetes	Hemophilia	Scarlet Fever
Anemia	Drug Addiction	Hepatitis A/B/C	Sickle Cell
Disorder Artificial Heart Valve	Emphysema	Herpes	Sinus Trouble
Artificial Joints	Epilepsy/Seizures	High/Low Blood Pressure	Stomach
Problems Arthritis/Rheumatism	Fainting/Dizzy Spells	HIV Positive	Stroke
Asthma	Fever Blisters	Kidney Trouble	Thyroid
Disease Blood Disorders	Glaucoma	Liver Disease	Tuberculosis (TB)
Bruise Easily	Hay Fever	Lung Disease	Ulcers
Cancer	Heart Disease/Attack	Mitral Valve Prolapse	Venereal Disease
Cold Sores	Heart Failure/Murmur	Organ Transplant	Yellow Jaundice

If you have any disease, condition or problem not mentioned above, please list:

Dental History:

Question		
1. Have you had regular dental exams in the past?	Yes	No
2. When was your last dental visit?		
3. What was done?		
4. Have you ever had abnormal bleeding or other problems associated with previous dental extractions or surgery?	Yes	No
5. Have you ever had Local Anesthetic?	Yes	No
6. Are you having dental pain?	Yes	No
7. Are you happy with the appearance of your teeth?	Yes	No
8. Do you have any oral habits such as clenching or grinding, nail biting or sucking your thumb?	Yes	No
9. Have you ever had professional tooth brushing and flossing instruction?	Yes	No
10. Do you brush daily?	Yes	No
11. Do you floss daily?	Yes	No
12. Do your gums bleed when brushing?	Yes	No
13. Do your gums bleed when flossing?	Yes	No
14. Do your gums bleed spontaneously?	Yes	No
15. Have you had any problems with or unpleasant reactions to dental treatment?	Yes	No

Consent

1. I certify that the above information is correct to the best of my knowledge.
2. I authorize the doctor upon consultation and direct consent from the patient/parent/guardian to perform diagnostic procedures, treatment and medication in the connection with the patients dental needs.
3. I understand that responsibility for payment of dental services, including insurance or otherwise, is due and payable at the time services is rendered and despite any dental insurance, I am ultimately responsible for any fees withheld by the insurance company.
4. I will not document on the internet any people or activities which occur in this office.

Patient Parent Guardian

Date Signature (Please select which one applies)