

# PATIENT REGISTRATION

<b>PATIENT'S NAME</b> _____ <b>Address</b> _____ _____ <b>Postal Code</b> _____ <b>Home Phone</b> _____ <b>Work Phone</b> _____ <b>Birthdate</b> ____Y ____M ____D <b>Age</b> ____ <b>Sex:</b> M F If a Child <b>Parent's Names</b> _____ <b>Mother</b> _____ <b>Father</b> _____ <b>Medical Doctor</b> _____ <b>Phone</b> _____ <b>Alberta Health Care No.</b> _____ <b>Whom can we thank for referring you?</b> _____ <b>Purpose of this visit</b> _____ <b>How would you like to be addressed?</b> _____ <b>Reason for leaving last dentist?</b> _____	THE INDIVIDUAL WHO IS RESPONSIBLE FOR THIS ACCOUNT _____ <b>Occupation</b> _____ <b>Employer</b> _____ <b>Business Address</b> _____ _____ <b>Postal Code</b> _____ <b>Business Phone</b> _____ <b>Ext.</b> _____ <b>YOUR SPOUSE:</b> <b>Name</b> _____ <b>Occupation</b> _____ <b>Employer</b> _____ <b>Business Address</b> _____ _____ <b>Postal Code</b> _____ <b>Business Phone</b> _____ <b>Ext.</b> _____
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<b>PRIMARY INSURANCE CARRIER:</b>	<b>1</b>
<b>INSURED PERSON</b> _____ <b>Social Insurance Number</b> _____ <b>Name of Insurance Co.</b> _____ <b>Policy Holder's Birthdate</b> ____Y ____M ____D <b>Policy / Group Number</b> _____ <b>Division / Class Number</b> _____ <b>Certificate Number</b> _____ Are you aware of the allowable frequency of dental cleanings? 6 months    9 months    12 months Are you aware of your yearly maximum and your insurance year end? YES    NO	

<b>SECONDARY INSURANCE CARRIER:</b>	<b>2</b>
<b>INSURED PERSON</b> _____ <b>Social Insurance Number</b> _____ <b>Name of Insurance Co.</b> _____ <b>Policy Holder's Birthdate</b> ____Y ____M ____D <b>Policy / Group Number</b> _____ <b>Division / Class Number</b> _____ <b>Certificate Number</b> _____ Are you aware of the allowable frequency of dental cleanings? 6 months    9 months    12 months Are you aware of your yearly maximum and your insurance year end? YES    NO	

<b>ARE YOU AVAILABLE ON SHORT NOTICE?    YES    NO</b>				
Mon	Tues	Wed	Thurs	Fri
AM	AM		AM	AM
PM	PM	PM	PM	PM
Please circle appropriate times.				

<b>If You are Covered by SOCIAL ASSISTANCE</b> Please Fill Out Section 3	<b>3</b>
<b>NAME OF CARD HOLDER</b> _____ <b>Social Assistance Number</b> _____ <b>Expiry Date</b> _____ <b>Coverage Type:</b> Standard    Supplementary	

In case of emergency, please notify:	<b>Name:</b> _____ <b>Phone #:</b> _____ <b>Relationship:</b> _____
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# MEDICAL HISTORY

The following information is required to thoroughly diagnose any condition and to give you the highest possible standard of professional services: All information will be kept strictly confidential.

- When did you have your last **complete** medical examination? Date \_\_\_\_\_
- Are you under the care of a medical doctor now or have been in the last two years? ..... YES NO  
If yes, what is the condition being treated? \_\_\_\_\_
- Have you had any serious illness or operation? ..... YES NO  
If yes, what? \_\_\_\_\_
- Are you presently taking any medication? ..... YES NO  
If yes, what? \_\_\_\_\_
- Within the last 6 months, have you taken any other medication not previously listed? ..... YES NO  
If yes, what? \_\_\_\_\_
- Do you have any known allergies or have you reacted adversely to any drug or medicine? ..... YES NO  
If yes, what? \_\_\_\_\_

• **Do you have or have you had any of the following diseases or problems?**

- |   |        |   |        |
|---|--------|---|--------|
| (a) Rheumatic fever or rheumatic heart disease? ...   | YES NO | (l) Gastrointestinal disorders e.g. ulcers? ....                            | YES NO |
| (b) Congenital heart defects or heart murmur? .....   | YES NO | (m) Nervous disorders e.g. depression? .....                                | YES NO |
| (c) Cardiovascular disease e.g. heart trouble, angina,<br>heart attack, high blood pressure, arteriosclerosis<br>(hardening of the arteries), stroke? ..... | YES NO | (n) Bone, muscle, or joint disorders<br>e.g. arthritis, osteoporosis? ..... | YES NO |
| (d) Chest pains or shortness of breath? .....   | YES NO | (o) Eye disorders e.g. glaucoma, cataracts? .                               | YES NO |
| (e) Asthma, hay fever, skin rash? .....   | YES NO | (p) Mononucleosis? .....  | YES NO |
| (f) Fainting spells or seizures (epilepsy)? .....   | YES NO | (q) Sexually transmitted diseases<br>e.g. syphilis, gonorrhea? .....        | YES NO |
| (g) Diabetes? .....   | YES NO | (r) Sinus troubles? .....   | YES NO |
| (h) Kidney disease? .....   | YES NO | (s) Blood disorders e.g. hemophilia,<br>anemia, leukemia ? .....            | YES NO |
| (i) Hepatitis, jaundice, or liver disease? .....  | YES NO | (t) HIV or AIDS? .....  | YES NO |
| (j) Endocrine disorders e.g. thyroid disease? .....   | YES NO | (u) Blood transfusion? .....  | YES NO |
| (k) Lung or breathing disorders<br>e.g. tuberculosis, emphysema? .....  | YES NO |   |        |

- Do you smoke? If yes, how much? ..... YES NO
- Have you had cancer? If yes, what type, how and when was it treated? ..... YES NO  
\_\_\_\_\_
- Have you had any abnormal bleeding associated with previous extractions, surgery, or trauma? ..... YES NO
- Do you bruise easily? ..... YES NO
- Do you have any disease, condition, or problem not previously listed? ..... YES NO  
If yes, what? \_\_\_\_\_
- Is there a history of family disease? If yes, what? ..... YES NO

### FOR WOMEN ONLY

- Are you taking oral contraceptives or other hormones? .....YES NO
- Are you pregnant? .....YES NO  
If yes, expected delivery date? \_\_\_\_\_  
Have you had any changes in your mouth since the pregnancy? .....YES NO  
If yes, explain: \_\_\_\_\_
- Are you breastfeeding? .....YES NO

## DENTAL HISTORY

Name of last dentist \_\_\_\_\_ Location \_\_\_\_\_  
Date of last dental visit \_\_\_\_\_ Past frequency of visits \_\_\_\_\_  
Date of last dental x-rays \_\_\_\_\_ How many taken? \_\_\_\_\_  
Frequency of brushing? \_\_\_\_\_ Frequency of flossing? \_\_\_\_\_

- Have you ever had tooth brushing instructions? .....YES NO
- Have you ever had instruction in using dental floss? .....YES NO
- Do you have frequent earaches, ringing in your ears, or occasional loss of hearing? .....YES NO
- Do you have pain or noise near your ears? .....YES NO
- Do you notice a clicking or cracking of the jaws **on** opening **or** closing? .....YES NO
- Do you suffer from frequent headaches, neck aches, or spells of dizziness? .....YES NO
- Have you ever had an injury to your head or jaws? .....YES NO
- Do sweets or cold consistently bother your teeth? .....YES NO
- Does heat or biting pressure consistently bother your teeth? .....YES NO
- Does food consistently catch between your teeth? .....YES NO
- Do you ever grind or clench your teeth? .....YES NO
- Do you have a bad taste or mouth odour? .....YES NO
- Do you have bleeding gums during brushing or bleeding for no apparent reason? .....YES NO
- Would you be disturbed if you had to wear false teeth? .....YES NO
- Are you dissatisfied with the appearance of your teeth? .....YES NO
  
- Have you ever had any of the following dental treatment?
  - Fillings .....YES NO
  - Periodontal (gums) .....YES NO
  - Wisdom teeth extracted .....YES NO
  - Crowns (caps) or bridges .....YES NO
  - Orthodontal (braces) .....YES NO
  - Root canals .....YES NO

# OFFICE POLICY

## APPOINTMENTS

Please help us maintain the operation of our office on sound principle so that we assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment this time **is reserved especially for you**. No charge to patients will be made for cancelled appointments provided 24 hours notice is received. **However, a charge may be applied for missed or broken appointments.\***

## INSURANCE

Dental plans in the marketplace today are too varied to allow us to know the details of them. We recommend you check with your dental plan for the details. (We are not responsible for insurance limitations, eg. frequency of exams, x-rays, cleanings, etc.). There may be certain procedures performed which are not covered through your dental plan. These are beyond our control.

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## TERMS OF PAYMENT

Payment for professional services will be requested when rendered. Any other arrangements **must be made in advance**. Cash, Debit Card, Mastercard and Visa will be accepted.

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## CONSENT

1. I hereby certify that the medical and dental history is accurate and complete to the best of my knowledge.
2. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic and any drugs indicated.
3. I understand that all diagnostic aids, including radiographs, are the property of the office.
4. **I FULLY UNDERSTAND THE OFFICE POLICY AND I ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THOSE PROCEDURES PERFORMED.**

PATIENT'S (PARENT'S) SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

CHILD'S SIGNATURE (if over 12) \_\_\_\_\_ DATE \_\_\_\_\_

## QUESTIONNAIRE UPDATE

Please review and update information, to ensure that all information is current and sign below.

- |                |                 |
|----------------|-----------------|
| 1. Date _____  | Signature _____ |
| 2. Date _____  | Signature _____ |
| 3. Date _____  | Signature _____ |
| 4. Date _____  | Signature _____ |
| 5. Date _____  | Signature _____ |
| 6. Date _____  | Signature _____ |
| 7. Date _____  | Signature _____ |
| 8. Date _____  | Signature _____ |
| 9. Date _____  | Signature _____ |
| 10. Date _____ | Signature _____ |
| 11. Date _____ | Signature _____ |
| 12. Date _____ | Signature _____ |