PATIENT REGISTRATION

PID#_____

Name of Client: _____ Male ☐ Female ☐

(Parent if CLIENT is under 16) _____ SIN# (optional) _____

Mailing address: _____ City: _____

Province: _____ Postal Code: _____ Birthdate: _____

Home Phone #: (___)_____ Business Phone: (___)_____ Ext._____

Previous Dentist: _____ Email Address: _____

Whom may we thank for this referral? _____

PERSON TO CONTACT IN CASE OF EMERGENCY Phone: (___)_____

Name: _____ Relationship to Client: _____

DENTAL INSURANCE Policy Holder ☐ Self ☐ Spouse ☐ Other

Place of Employment _____

Ins. Company: _____ Policy# _____ ID# _____

We are committed to keeping your personal information private.
By signing the consent form, you have agreed to give your consent for the collection, use and/or disclosure of your personal information for the purposes that are listed in our Privacy Policy. If a new purpose arises for the use and/or disclosure of personal information, we will seek your approval in advance. A copy of our Privacy Policy is available in the reception area.

PAYMENT OPTIONS

To keep costs down and continue to provide quality dentistry, we can only accept payment in full, same day of service. Please check the method of payment you prefer to settle your account in full.

CASH/INTERACT ☐ **VISA** ☐ **MASTERCARD** ☐

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% monthly interest charge (18% annually) will be added to any balance over 60 days. In the event of default, I (we) promise to pay any interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required, to effect collection of this note.

PRINT NAME: _____ **DATE:** _____

SIGNATURE: _____

CONSENT

The undersigned hearby authorize the Doctor to take x-rays, study models, photographs or any other diagnosis of my (or the patients) dental needs. I further give permission for the use of these photographs, x-rays and records to be used for the purpose of research, education or publication in professional journals. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I further authorize and consent that the Doctor choose and employ such assistance, as he deems fit. I also understand that the use of anaesthetic agents embodies a certain risk. Where possible, I will be asked for verbal consent or permission before any and all treatment is done and x-rays are taken.

- Patient Signature _____ Date _____

or

- PARENT OR RESPONSIBLE PARTY _____
- RELATIONSHIP TO PATIENT _____

PLEASE COMPLETE ALL OF THE BELOW:

Office Use Only
Initial BP /

DENTAL HISTORY

1. DO YOU SMOKE? YES NO How Much?.....
2. Are you having any discomfort at this time?..... YES NO
3. Do you feel nervous about having dental treatment?..... YES NO
4. Have you ever had a bad experience in the dental office?..... YES NO

HEALTH HISTORY

5. Physician's name..... Phone.....
6. Date of your last physical?.....
7. Have you taken any medicine or drugs in the last two years?..... YES NO
8. **Please list any medications you are presently taking**.....

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9. Do you have any allergies?..... YES NO
10. Have you ever been told you should take an antibiotic before dental treatment?..... YES NO
11. Have you ever taken Alendronate (Fosamax), Editronate (Didrocal), Risedronate (Actonel) or Pamidronate (Aredia)?
12. Have you ever had a peculiar or adverse reaction to any of the following? (Please Circle)

Latex Nitrous Oxide Local Anaesthetic (or dental freezing) Penicillin Asprin

Other (Please specify).....

13. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	HIV	A.I.D.S.
Heart Disease or attack	Angina pectoris	Tuberculosis	{Hepatitis_____
High blood pressure	Asthma	Diabetes	{Infection or Serum
Heart Murmur	Hay Fever	Ulcers	Yellow Jaundice
Rbeumatic Fever	Sinus Trouble	Heamphilia	Blood Transfusion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction	Fever blisters
Scarlet Fever	Thyroid Disease	Venereal Disease	X-ray/Cobalt treatment
Artificial Heart Valve	Arthritis	Epilepsy/Seizures	Chemotherapy?Cancer
Heart Pacemaker	Rheumatism	Nervousness	Sickle Cell Disease
Heart Surgery	Cortisone Medicine	Glaucoma	Psychiatric treatment
Stroke	Artificial joints (hips/knees)	Bruise easily	Anemia
Kidney Trouble	Osteoperosis	Pain in the Jaw Joints	Liver Disease

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14. When you walk upstairs or take a walk do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired?..... YES NO
15. Do your ankles swell during the day?..... YES NO
16. Do you use more than 2 pillows to sleep?..... YES NO
17. Have you lost or gained more than 10 pounds in the past year?..... YES NO
18. Do you ever wake up from sleep short of breath?..... YES NO
19. Are you on a special diet?..... YES NO
20. Has your medical doctor ever said you have cancer or a tumour?..... YES NO
21. Do you have any disease, condition or problem not listed?..... YES NO

Please Specify.....

FOR WOMEN ONLY ..... are you pregnant? yes☐ no☐ If yes, what month.....?

..... are you taking birth control pills? yes☐ no☐

Signature_____

Witness_____ Date_____