PATIENT REGISTRATION FORM

Information provided will be kept confidential

Last Name:		First Name:	Preferred Name:
Address:			Date of Birth:
City:	Province:	Postal Code:	Gender: Male / Female
Email address:			
Home Phone:		Cell Phone:	Work Phone:
Occupation:		Employer:	
Family Doctor		Doctor Phone:	
Emergency Contact:		Relationship to Patient:	Emergency Phone:
Whom may we thank for referring you?			Relationship to patient:
If not, how did you hear about us? Drive-By / Walk In / Internet Search (Google) / Newspaper / Friend			
Who is responsible for this account?			Relationship to patient:

DENTAL HISTORY

Reason for this visit?	Last dental visit?
Name of your previous dentist:	X-Rays taken within the last 12 months? Yes / No
How often do you brush?	How often do you floss?
Do your gums ever bleed?	Do you have loose or drifting teeth?
Do you know if you grind your teeth?	Does your jaw click, pop or hurt?
Are you satisfied with the appearance of your teeth?	
Have you had any complications or difficulty with previous dental treatment? If yes, please explain	
How do you rate yourself as a dental patient? Calm / Slightly Nervous / Very Anxious	

MEDICAL HISTORY

Are you currently in good health? If no, please explain		
Are you under the regular care of physician? (other than regular check-ups) If yes, please explain		
Have you ever had a serious illness or operation? If yes, please explain		
Do you currently have or ever had any of the following conditions? Please **CIRCLE** all those that apply		
• Anemia • Arthritis • Artificial Joints • Asthma • Blood Disease • Cancer • Contraceptive Use • Diabetes • Dizziness/Fainting • Emphysema • Epilepsy • Excessive Bleeding • Excessive Bruising • Gasto-Intestinal	• Glaucoma • Hay Fever • High Blood Pressure • Head Injury • Hearing Disabled • Heart Disease • Heart Murmur • Hepatitis A B C • HIV + (AIDS) • Jaundice • Kidney Disease • Low Blood Pressure • Liver Disease • Psychiatric Care	• Multiple Sclerosis • Nervous Disorders • Pacemaker • Radiation Treatment • Respiratory Problems • Rheumatic Fever • Sinus Problems • STD • Stomach Problems • Stroke • Thyroid Disease • Tuberculosis • Tumors • Ulcers
Are you allergic to or ever had a reaction to any of the following?		
• Aspirin (ASA) • Codeine	• Local Anesthetic • Penicillin/Amoxicillin	• Sulpha Drugs • Other: _____
Do you smoke? If yes, how long?	Have you have had a persistent cough for the last 24 hours?	
Women: are you pregnant? If yes, how many weeks pregnant?		
Are you currently on blood thinners?		
Any other physical conditions of which the doctor should be aware of?		
Are you currently taking any medications or vitamins? If yes, please list		
Signature		Date