

DATE _____

P.T.I.D.# _____

MEDICAL ALERT _____

WELCOME TO OUR OFFICE

The following information is required by the dentist to assist in proper diagnosis and treatment. Please feel free to ask the receptionist for help in completing this form. PLEASE PRINT.

PATIENT REGISTRATION

Dr ___ Mr ___ Mrs ___ Ms ___ Miss ___ Child ___

Name: _____
Last First Initial

Address: _____
Street City Prov. Postal Code

Date of Birth _____ Sex ___ M ___ F ___ Marrital Status _____
M/D/Y

Occupation _____ Home Tel.# (____) _____ Bus.Tel. (____) _____

Referring Dr. _____ Tel # (____) _____

Family Physician _____ Tel # (____) _____

Emergency Contact Person: _____ Tel # (____) _____

Whom may we thank for referring you? _____ Add: _____ Other: _____

What is the reason of today's visit? _____

Person Responsible for the account: Self Spouse Other If Other Please complete the following _____

Name: _____
Last First Initial

Address: _____
Street City Prov. Postal Code

Employer: _____ Tel. #(____) _____

DENTAL INSURANCE ___ YES ___ NO

Subscriber _____ Primary

Insurance Company _____

GR/Policy # _____

I.D./ Cert. # _____

Date of Birth _____
M D Y

S.I.N. # _____

Max Coverage _____% For _____ Basic _____

Major _____ % Orthodontic _____

Deductible _____

Subscriber _____ Secondary

Insurance Company _____

GR/Policy # _____

I.D./ Cert. # _____

Date of Birth _____
M D Y

S.I.N. # _____

Max Coverage _____% For _____ Basic _____

Major _____ % Orthodontic _____

Deductible _____

MEDICAL HISTORY (this information will remain confidential)

Medical Alert

YES NO

- 1. Are you presently under the care of a physician? If so explain. _____
- 2. Have you ever had a serious illness or been hospitalized? If so explain. _____
- 3. Are you taking any drugs or medication at this time?...Drug _____ Reason _____
- 4. Have you ever had an adverse effect to any of the following: Aspirin , Barbiturates (sleeping pills)
Antibiotics - (Penicillin , Sulfonamide , Other), Codeine , Darvon , Local Anaesthetic
- 5. Have you ever been warned against using any other medication? If so which? _____
- 6. Have you ever taken prolonged medical or non-medical drugs? Specify _____
- 7. Do you suffer from any allergies (hay fever, latex, etc...)? If so which ones? _____
- 8. Do you bruise easily or have prolonged bleeding? _____
- 9. Do you smoke? If so how much? _____
- 10. Have you ever fainted, had shortness of breath or chest pains? _____

11. Women: Are you pregnant? Yes No Have you reached menopause? Yes No Are you taking birth control? Yes No

12. Do you or have you ever had any of the following? Please check appropriate boxes

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> A.I.D.S. | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease/attack | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic/Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sickle cell disorder |
| <input type="checkbox"/> Angina pectoris | <input type="checkbox"/> Congenital heart lesions | <input type="checkbox"/> Heart pacemaker/surgery | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Anorexia nervosa | <input type="checkbox"/> Cortisone/steroid | <input type="checkbox"/> Heart rhythm disorder | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach/intestinal prob. |
| <input type="checkbox"/> Arthritis/rheumatism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Drug/Alcohol dependence | <input type="checkbox"/> Herpes | <input type="checkbox"/> Malignant hyperthermia | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Artificial joints (hip, knee) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Mental/nervous disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> H.I.V. Positive | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Glandular disorders | <input type="checkbox"/> Hodgkins disease | <input type="checkbox"/> Organ transplant/implant | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hyper (Hypo) Glycemia | <input type="checkbox"/> Psychiatric treatment | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Head/neck inuuries | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Radiation/Chemotherapy | <input type="checkbox"/> None |

13. Children Only: Have you recently had any of the following (approximate date) Chicken Pox _____
 Measles _____ Mumps _____ Strep Throat _____ Tonsilitis _____

DENTAL HISTORY

- 1. What is the reason for today's visit? Examination Emergency Other
- 2. How often do you see a dentist? Every _____ months When was your last dental visit? _____ Last X-Ray? _____
- 3. How often do you brush? _____ per day Floss? _____ Use Antibacterial rinse? _____
- 4. Are your teeth sensitive to: Cold Sweets Heat Other
- 5. Do your gums bleed when: Brushing Flossing Never **YES NO**
- 6. Do your gums feel swollen or tender? _____
- 7. Do you have bad breath or bad taste in your mouth? _____
- 8. Do your jaws crack, pop or grate when you open widely? _____
- 9. Do you grind or clench your teeth? _____
- 10. Do you have food catch between your teeth? _____
- 11. Have you ever had local anaesthetic (freezing)? Any complications? Yes No Specify _____
- 13. Have you ever had any of the following treatments? Crowns or Caps Full or Partial Dentures
 Periodontal (Gums) Bridgework Orthodontic (braces) Root Canal NONE
- 14. Are you satisfied with the appearnace of your teeth? Specify: _____

GENERAL RELEASE: I, the undersigned, understand that the information contained in th the dental and medical history portion of this chart is important to my treatment. I certify that all information is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatments for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

Signature Print Name Date