



Patient Registration

All information is confidential



PATIENT: _____

First Name _____ Last Name _____ Preferred Name _____
Date of Birth (D/M/Y): _____ Age: _____ Sex: _____ Marital Status: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell phone number for text message confirmations: _____

E-mail address for confirmations: _____

If under 18 years of age, Parent or Guardian name: _____

Person to call in case of emergency: _____
First Name _____ Last Name _____ Date of Birth (D/M/Y) _____ Phone Number _____
Cell #: _____

Whom may we thank for referring you? _____
First Name _____ Last Name _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important inter relationship with the dentistry that you will be receiving. Thank you for answering the following questions. **All information is confidential.**

1. When was your last medical exam? _____ Physician's Name _____

Are you presently under the care of a physician or have you been during the last 5 years? Yes No

If Yes, explain: _____

2. Have you ever had a serious illness, accident requiring hospitalization or extensive medical care? Yes No

Specify: _____

3. Do you use any prescription or non-prescription medicine (including birth control)? If so please list:

Drug _____ Reason _____

Drug _____ Reason _____

Drug _____ Reason _____

4. Have you ever experienced any unusual reaction to any of the following? (please check)

- local anaesthesia sulfa drugs latex/rubber aspirin (ASA) erythromycin
- barbiturates penicillin metal (nickel) codeine other _____

Have you ever been warned against taking any drug or medication? Yes No If Yes, please specify _____

5. Do you have or have you ever had any of the following (Please check and or circle)

- arthritis or rheumatism epilepsy or seizures hyper or hypo glycemias stomach/intestinal problems
- asthma fainting or dizziness jaundice stroke
- back problems heart attack kidney/liver disease thyroid disease
- cancer/radiation/chemo heart murmur/mitral valve prolapse malignant hyperthermia tumors
- convulsions herpes mental or nervous disorder other _____
- cortisone/steroid therapy hepatitis A B or C organ/medical implants
- diabetes HIV positive scarlet or rheumatic fever
- drug/alcohol addiction high low blood pressure sinus trouble

6. Do you have any blood disorders such as anemia? Yes No

7. Have you ever had any injury, surgery or x-ray therapy to your face or jaws? Yes No

If Yes, explain: _____

8. Do you have frequent severe headaches? Yes No

9. Do you have any disease, condition or problem that you think the doctor should know about? Yes No

WOMEN ONLY Are you pregnant? Yes No If Yes, what month are you in? _____

PATIENT CONSENT AND APPROVAL

I have had the opportunity to ask and to receive answers or explanations regarding my medical/dental history. I, the undersigned, certify that all of the medical and dental information is true to my knowledge and I have not omitted any pertinent information. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary and consent to my physician being contacted if necessary.

Signature: _____

Date: _____

day/month/year