Medical Alert For Office Use

Patient Registration Form –

Patient Information

Salutation _____ Last Name_____ First Name _____
Preferred _____ Date of Birth _____ Sex _____
Address _____
City/Province _____ Postal Code _____
Telephone number (home) _____ Work _____ext. _____

May we contact you at your workplace? Yes ☐ No ☐
May we contact you on your cellular phone? Yes ☐ No ☐ Cell Number_____
May we contact you by e-mail? Yes ☐ No ☐ E-mail address _____

Name of Employer _____ Position _____

Best Contact Telephone ☐ Morning ☐ Afternoon ☐ Evening ☐ E-mail ☐
Continuing Care Cycle _____ months

Insurance Information

Person Responsible for Account /Guarantor/Parent or Guardian (if different from above)
_____ Contact number _____
Family Members:
_____

Family Physician _____ Telephone number _____
Medical Alert/Allergies Yes ☐ No ☐ **(If yes, refer to medical history)**
In case of Emergency – Please notify_____

Primary Carrier
Name of insurance carrier _____
Address _____
Name of Subscriber _____
Eligible Members & Relationship
_____
Group Policy Number _____
I.D.Number_____

Fee Guide Year _____EDI_____Deductible _____Family ☐ Patient ☐ None ☐
Amount _____Coverage Year End _____Annual Maximum_____
Exclusions/Limitations _____

Diagnostic % _____
Preventive % _____
Restorative% _____
Major Restorative %_____

Periodontics%_____
Endodontics% _____
Orthodontics% _____
Specialist _____

Other Information

1. How did you hear about us? _____
2. How long since your last dental visit? What was done at that time? _____
3. Do you have a special reason for this visit? _____
4. What, if anything, in the past has kept you from having dental treatment? _____
5. Can you eat anything your want, whenever you want? _____
6. What are the positive or negative aspects of your dental health? _____
7. It's valuable for me to know how you feel about your smile. Could you tell me?_____
8. What has dentistry been like for you?_____
9. What do you most look for from a dental office?_____

DENTAL HISTORY

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

Do you have a specific dental problem?	Yes	No
If so, describe _____		
Do your gums bleed when you brush?	Yes	No
Do you ever experience a bad taste in your mouth?	Yes	No
Do you experience frequent gumboils or swelling of the gums?	Yes	No
Are your gums shrinking and your teeth getting longer?	Yes	No
Are any of your teeth sensitive to heat or cold?	Yes	No
Are any of your teeth sore to chew on?	Yes	No
Does your jaw ever "click" or "crack?"	Yes	No
Have you ever had a jaw or mouth injury?	Yes	No
Do you clench or grind your teeth?	Yes	No
When was your last dental treatment? _____		
Did you have x-ray taken at the last appointment?	Yes	No

MEDICAL HISTORY

Medical Alert Yes ☐ No ☐

Your answers will help me to determine a proper and safe treatment for you. The information is confidential and will be kept in your dental chart. On subsequent visits, any change in your health should be reported.

PHYSICIAN'S NAME _____ PHYSICIAN'S PHONE NUMBER _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Are you in good health? _____ Are you presently under the care of a physician? _____
If so, for what? _____
When was your last medical examination? _____
Do you have allergies?_____
Are you taking any medication? _____ If so, what? _____
Are you allergic to any medications? _____ If so, what? _____
Have you ever had a bad reaction to local anesthetic? _____ If so, describe _____
Has your physician every told you to take antibiotics prior to dental procedures? _____
If so, why? _____
Have you every experienced complications following a medical or dental procedure? _____
If so, describe _____
Have you ever had joint replacement? _____ Do you smoke?_____
Have you ever had a problem with alcohol or drug dependency? _____
For women only: Do you take birth control pills? _____ Are you pregnant? _____

DO YOU NOW, OR HAVE YOU EVER HAD THE FOLLOWING (Please answer yes or no to each)

1. A known heart condition? Yes No
2. If yes, please describe_____
3. Do you have a heart murmur _____pace maker _____bleeding problems _____mitral valve prolapse _____
4. Have you ever been diagnosed with high blood pressure? _____
5. Have you ever had hepatitis? _____ (A – B – C)
6. HIV _____
7. Have you ever had Rheumatic Fever? _____

Is there anything we have not mentioned that you think we should know regarding your medical history? _____

I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me. If required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist and his/her auxiliary staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided.

Consent for Collection, Use and Disclosure of Personal Information

I agree that Dr_____ has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have been provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the *Personal Health Information Protection Act, 2004.*

Date_____ _____

Signature