WELCOME TO OUR DENTAL OFFICE (For office use only)

Date			MEDICAL ALE	RT V N
The information that is requested on this Q with the highest standard of dental care. our office and we are committed to collect	The protection a	and privacy of your pers	listory is essential onal information	to providing you is important to
REGISTRATION INFORMATIO	N - This informa	ntion will enable us to maint	ain communication	with you.
The patient is an: Adult Child Adul	t under guardiansl	nip 🗌 Name of Guardian: _		
Name: (last)	(first)	(initial) Dr. [☐ Mr. ☐ Mrs. ☐	Ms. Miss
Prefers to be called:		Language Preference:		The second second
Address: (street)	(apt.#)	(city)	(province) (po	ostal code)
Home Phone: ()	ditional registratio	n information if required by	office:	
		::E-Mail addres		
Date of Birth: MDY Age: Preferred appointment time:	Sex: N	Marital Status: Name	e of Spouse:	
Are other family members patients at our offi	No. of the last of			1
MEDICAL PRIORITY - This inform				- Aller - Alle
Family Physician:	lation will chable		hone: ()	120 Parkan Constant (Inc.)
Medical Specialist: (if presently under care)			Phone: ()	
(if presently under care) In case of emergency, please contact:		The second secon		
Nearest relative not living with you:			Phone: ()	
Reason for today's visit? Examination Examination Examination				
Is there a dental problem you would like trea				
FINANCIAL INFORMATION - T				
Person responsible for account: Self Sp			nation only if differe	ent than above.
Name: (last)	(first)	(initial)	Phone: ()	and a provided in
Address: (street)	(apt.#)	(city) (province		2)
Employed by:		P	hone: ()	
Additional financial information if required by	y office:	The second secon		
METHOD OF PAYMENT (For office use only) C	ASH CHEQ	UE CREDIT CARD	OTHER [The second secon
PRIMARY DENTAL INSURANCE (C.	omplete information only	y if required by office) SECON	DARY DENTAL	INSURANCE
Subscriber's name:	D.O.B.	Subscriber's name:		D.O.B.
Emp./Grp. policy holder:	Ins. yr. end	Emp./Grp. policy holder:		Ins. yr. end
Ins. Co.	Tel.	Ins. Co.		Tel.

Gгр./Ind. policy No.

% coverage: Basic

Maj. Rest.

I.D.#

Cert. No.

Max. Coverage.

Other

Grp./Ind. policy No.

% coverage: Basic

I.D.#

Cert. No.

Ortho.

Maj. Rest.

Max. Coverage.

Other

Other

Is there a dental problem you would like treated immediately? Yes \ No \ Yes	DENTAL HISTORY Please YES or NO to each question. If ur	nsure of a question, please consult with the der	ntist.
1. Have you been seeing a dentist regularly? 2. Have you ever had any of the following? 2. Periodontal Treatment? (treatment of the gums) 2. Periodontal Treatment? (treatment of the gums) 3. A bite plate or any other appliance? 4. Your bite adjusted or teeth ground? 5. To coll surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?) 18 If you answered "yes" to the last question, who performed the surgery? 4. Are you being followed up by a dental specialist? 3. Are there any growths or sore spots in your mouth? 4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? 5. Have you noticed any loose teeth, or, have any of your teeth shifted? 6. Does food eath between your teeth? 7. Are any of your teeth sensitive to heat, cold, sweets or pressure? 8. Have you been advised to take antibiotics before a dental appointment? 9. Do you use dental floss, proxabrush or stimudents? How offen? 10. How offen do you brush your teeth? 11. Have you ever experienced any of the following jaw problems: 12. Popping/clicking in your jaw joints? 13. Pain in your jaw joints, around your ear, or side of your face? 14. Pain in your jaw joints, around your ear, or side of your face? 15. Pain when teeth are clenched? 16. Pain when teeth are clenched? 17. Pain when teeth are clenched? 18. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? 18. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? 19. Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? 19. On a scale of 1 to 10, 10 being highest, how important is it for you to keep your natural teeth? 10. Do you feel your dental health influences your overall health? 11. On a scale of 1 to 10, 10 being highest, how important is it for you to keep your	Is there a dental problem you would like treated immediately? Yes \square No \square	Y	ES N
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FORM: RMSPRDHC REV:7

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Name:				D.0	O.B.			Patient/Parent/Guardian Initial:	Date:		
Please VYES or NO to	each	questio	n. If unsure of a question, ple	ase co	nsult	with	the	dentist.		YES	NO
1. Are you being treate	ed for a	any med	lical condition at present or wi	thin the	e pas	t two	year	s? If yes, please	explain:		
2. Have you been hosp	italized	in the p	Physicia past two years? cian? Last co ently, taking any prescription of					I none.			
When was your last: Have you recently of	visit to	a Physic	cian? Last co	mplete	phys	sical e	exami	nation?	madiaa		
1	n are y	ou pres	ontry, taking any prescription (JI HUH-	bi es	cupe	1011 G	rugs mer. nerbai re	medies		
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5. Have you ever reacted aspirin, codeine, local	ed adve	rsely to	5. any medications or injections? freezing), nitrous oxide, or any o	(Please	_ o. circ edici	le.) e	.g.Per	nicillin, or otherant	ibiotics		
			taking any specific type of med								
7. Do you have any of	the foll	owing?	Asthma, Hay Fever, Food Alle	rgies, N	Meta	l or L	atex A	Allergies, Skin Ras	hes,		
Hives, or any othe 8. Do any of these alle	rgic cor	gic cond nditions	ditions? result in headache, nausea, swe	elling, s	short	ness	of bre	ath, or chest const	riction?		
it co mignes overlain.			, Cancer or Heart Disease? 1 a cut or injury, or bruise easily								
 Do you bleed EXCE Do your ankles, feet 	SSIVE or han	LY fron ds swell	n a cut or injury, or bruise easily	?							
12. Has your weight, app	petite of	r energy	level changed dramatically rec	ently?						IH	
14. Do you experience s	ciai diei hortnes	s of bre	you on a diet pill therapy?	walk or	clim	hina	etaire	9			
15 Have von or anvone	112 7/0131	r tamaila	tacted HIV nocitive or have He	matitic	A D	(19)					
10. Do you have Fixed	ULINI	OLVEN	E Headaches, caraches, car/fillo	at intec	CHOTES	1				H	IH
 Have you ever had a Do you wear eyeglas 	ny minu	ry or su	rgery to your face or jaws?								
19. Do you have any her	aring di	ifficultie	es?								IB
			ns of tobacco?								
21. Are you alcohol and	or drug	ansuerm g depen	dent?								
and, Have you r	eceived	d treatm	ent?								Н
22. INDICATE WHICH			LOWING YOU PRESENTLY			EVEF	RHAI	D:			
	YES	NO		YES	NO						
A.I.D.S.			Glaucoma			Lup					
Anemia			Head/neck injuries					Hyperthermia			
Angina pectoris Arthritis/rheumatism			Heart disease or attack Heart murmur					rvous disorder			
Artificial heart valve			Heart pacemaker					ve prolapse isplant/medical impl	ont		
Artificial joints(hip, knee)			Heart rhythm disorder					c treatment	3110		
Blood disorders			Heart surgery					treatment/chemother	any		
Bronchitis			Hepatitis A B C			Scar	let fev	ver → Rheumat	ic fever		
Cancer			Herpes					disease	#1		
Circulation problems			High/Low blood pressure				is trou				
Congenital heart lesions			Hodgkins disease					ntestinal problems/U	lcers		
Cortisone/steroid			Hyper (Hypo) Glycemia			Stro					
Crohn's disease Diabetes			Hypertension					isease			
Emphysema			Inflammatory bowel disease				erculo				
Epilepsy or seizures			Jaundice Widney disease					Disease			
Fainting or dizzy spells			Kidney disease Liver disease			Oth	er			-	
Glandular disorders			Lung disease			Oth	er 				The second secon
23. Has the CHILD PATIF	INT roc	ently	Measles	tot	П						
had any of the followi		cinty	Mumps Chicken Pox			Stre	p thro	at			
(indicate approximate			Chicken Pox			Ton	sillitis				
24. Do you currently have	ve, or h	ave you	had in the past, any disease, co	ndition	or p	roble	m not	listed above?			
26. Do you wish to spea	k priva	itely to t	health we should be made awa the Doctor about any problem o	r medio	cal co	onditi	on?_				
27. Women only: Are yo	u pregna	ant or sus	spect you may be? Expected	deliver	y date	e?		Are you breast feedi	ng?		
Are you taking any bir	th contr	ol pills?	— Women over 50: Are yo	ou aware	e of y	our bo	one mi	ineral density? ——			

Date	MEDICAL NOTES	Ini
Have you cha	anged your Family Physician? Yes No New Physician:	Phone:
	er the care of a Medical Specialist? Yes \(\square\) No \(\square\) Specialist:	
	y changes to your Health History? Yes 🗆 No 🗆 Please specify:	5.5.
Are you takin	NLY: Are you pregnant or suspect you may be? Expected delivery date? ng any birth control pills? WOMEN OVER 50: Are you aware of your be leations currently being used (including herbal remedies): 1	one mineral density (BMD)?
	4 5,	6
	Date:	Reviewed by:
		Initials: Date:
Have you cha	anged your Family Physician? Yes No New Physician:	Phone:
Are you unde	er the care of a Medical Specialist? Yes No Specialist:	Type:
Are there any	y changes to your Health History? Yes 🗆 No 🗀 Please specify:	
Are you takin	NLY: Are you pregnant or suspect you may be? Expected delivery date? ng any birth control pills? WOMEN OVER 50: Are you aware of your be leations currently being used (including herbal remedies): 1	one mineral density (BMD)?
	4 5	6
	Date:	Reviewed by:
	Signature: Patient 🗆 Parent 🗀 Guardian 🗆 Doctor's	Initials: Date:
Have you cha	nanged your Family Physician? Yes \(\square\) No \(\square\) New Physician:	
Are you unde	er the care of a Medical Specialist? Yes No Specialist:	Type:
Are there any	y changes to your Health History? Yes 🗌 No 🗀 Please specify:	
	NLY: Are you pregnant or suspect you may be? Expected delivery date? ng any birth control pills? WOMEN OVER 50: Are you aware of your beautiful and the property of the property o	
	ications currently being used (including herbal remedies): 1 5	
J	Date:	
		Initials: Date:
Have you cha	nanged your Family Physician? Yes \(\square\) No \(\square\) New Physician:	Phone:
		Type:
Are there any	y changes to your Health History? Yes 🗌 No 🗀 Please specify:	The state of the s
WOMEN ON	NLY: Are you pregnant or suspect you may be? Expected delivery date?	Are you breast feeding?
List all medic	ing any birth control pills? WOMEN OVER 50: Are you aware of your b ications currently being used (including herbal remedies): 1 4 5	2 6
List all medic	ications currently being used (including herbal remedies): 1.	2 6

FORM: RMSMHUC REV:10