REGISTRATION AND HEALTH HISTORY

Mr. Mrs. Ms. Dr. _____, _____ _____
(Last Name) (First Name) (Middle Name)

Residence Address _____
(Street) (City) (Province) (Postal Code)

Home Phone _____ Business Phone _____ Cell Phone _____

Date of Birth (Y/M/D) _____ Care Card Number _____

Marital Status: Single, Married, Widowed, Divorced, Common Law
Name and Address of Employer _____
Name of Spouse _____
Name and Address of Spouse's Employer _____
If under 19, please provide name of parents and/or guardians _____
Referred By: _____

DENTAL INSURANCE

Primary Insurance

Name of Insurance Company _____ Policy Holder _____
Policy/Group # _____ Certificate/ID # _____
Policy Holder's Birthday _____ Coverage % _____

Secondary Insurance

Name of Insurance Company _____ Policy Holder _____
Policy/Group # _____ Certificate/ID # _____
Policy Holder's Birthday _____ Coverage % _____

MEDICAL HISTORY

Name of Physician _____ Date of Last Visit _____

Do you have or have you had any of the following:

__ Heart problems
__ High blood pressure
__ Low blood pressure
__ Circulatory problems
__ Nervous problems
__ Kidney problems
__ Cancer/tumor
__ Alcohol and/or Drug Addictions
__ Hip and/or Joint Replacements
__ Anemia
__ Arthritis
__ Asthma
__ Epilepsy
__ Diabetes
__ Stroke
__ Ulcers
__ Hepatitis A/B/C
__ AIDS/HIV +
__ Venereal/genital disease
__ Tuberculosis (TB)
__ Psychiatric Care
__ Radiation/Chemo treatment
__ Measles
__ Shortness of Breath
__ Allergies to Anesthetics
__ Scarlet Fever
__ Rheumatic Fever
__ Typhoid Fever
__ excessive bleeding
__ Sinus problem
__ Fainting spells
__ Pacemaker
__ Hemophilia
__ Other allergies _____

Do you have any diseases, conditions, and/or medical problems not listed above? _____
_____

Are you currently on any medications? Do you have any other medical information which you think may be relevant to your dental visits? _____

Are you pregnant? _____ Due Date: _____

Please inform our office of any changes in your health and/or medications, by phone or at your next dental appointment.

DENTAL HISTORY

Name of last dentist _____
Address of Last Dentist _____
Date of Last Visit _____

Have you had dental x-rays taken in the last 12 months? (Yes / No) _____

Have you ever had injury or trauma to your jaw or face? (Yes / No) _____
_____

Do you have pain in your jaws? (Yes / No) _____
_____

Do you have frequent headaches? (Yes/ No) _____
_____

Have you ever had a reaction to local anesthetics? (Yes/No) _____

Do you need any premedications before any dental work? (Yes/No) _____

Are you having any discomfort? _____
_____

I understand that payment is due upon services being rendered and any balance not paid by my dental insurance is my financial responsibility. Interest of 2% will be added monthly on any unpaid amounts.

Date _____ Signature _____
(if under 19, parent/guardian must sign)