**REGISTRATION & HEALTH HISTORY**

**Contact Information**

Mr. / Mrs. / Ms. / Miss. / Dr.

Surname: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**First Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Middle Initial: **\_\_\_\_\_\_**Preferred Name:**\_\_\_\_\_\_\_**

Gender: Female**\_\_\_\_\_\_** Male **\_\_\_\_\_\_** Birthdate: M/D/YY **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Care Card # **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City: **\_\_\_\_\_\_\_\_\_\_\_\_\_**Province: **\_\_\_\_\_\_\_\_\_\_** Postal Code: **\_\_\_\_\_\_\_\_\_**

Home Phone: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cell Phone: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Work Phone **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Preferred Contact Number: H**\_\_\_**C\_**\_\_** W\_**\_\_**  Email: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Emergency Contact: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Relationship:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Home Phone: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Cell Phone: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Referred By: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History**

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you in good health? Yes **\_\_\_\_** No **\_\_\_\_** if no, please provide details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. When was the last time you had a medical examination? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. Do you have any heart or circulatory problems? Yes**\_\_\_\_\_** No **\_\_\_\_\_**. Do you have a pacemaker? Yes **\_\_\_\_** No **\_\_\_\_**
4. Do you have any allergies? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. Please indicate (**X**) below if you presently have or have ever had any of the following:

|  |  |  |
| --- | --- | --- |
| * **Alzheimer’s Disease**
 | * **Epilepsy/Seizures**
 | * **Excessive Bleeding**
 |
| * **AIDS/HIV**
 | * **Fainting/Dizzy spells**
 | * **Rheumatic Fever**
 |
| * **Alcohol and /or drug addictions**
 | * **Heart Problems**
 | * **Thyroid Problems**
 |
| * **Arthritis or Rheumatism**
 | * **Hemophilia**
 | * **Tuberculosis (TB)**
 |
| * **Asthma**
 | * **Hepatitis A/B/C**
 | * **Venereal/Genital Disease**
 |
| * **Anemia**
 | * **High/Low Blood Pressure**
 | * **Measles**
 |
| * **Cancer/Radiotherapy/Chemotherapy**
 | * **Hyper/Hypo glycaemia**
 | * **Stroke**
 |
| * **Diabetes: Type:\_\_\_\_\_\_\_\_\_ Last A1C Reading: \_\_\_\_\_\_\_\_\_ Date of Reading: \_\_\_\_\_\_\_\_\_\_**
 |
| * **Eating Disorders**
 | * **Kidney Problems**
 | * **Typhoid fever**
 |
| * **Mental or Nervous disorder**
 | * **Sinus Problems**
 | * **Lung Disease**
 |
| * **Bruise easily**
 | * **Chest Pains**
 | * **Ulcers**
 |

1. Do you have or have you ever had any other diseases, conditions or medical problems not listed above?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Scanned by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. Are you currently taking any kind of medication (including prescription, non-prescription, recreational, herbal supplements etc.)? if yes, please specify:

Drug \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Reason **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Drug **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Reason **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Drug **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Reason **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Drug **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Reason **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Drug **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Reason **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Drug **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Reason **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **If you need additional space, please write on the bottom of the page or ask for additional paper.**

1. Have you ever been advised to take antibiotic pre-medication prior to dental treatment? Yes **\_\_\_** No**\_\_\_**. If yes, why
**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. Do you smoke? Yes **\_\_\_** No **\_\_\_** if yes, how much a day? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** For how many years? **\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. Female patients: Are you pregnant or think you may be pregnant? Yes **\_\_\_\_** No **\_\_\_\_**

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

**Dental History**

Name & Address of Last Dentist: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date of Last Visit: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Purpose of Last Visit: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Have you had dental x-rays in the last 12 months? Yes **\_\_\_\_** No **\_\_\_\_**
2. Have you ever had injury / trauma to your jaw or face? Yes **\_\_\_\_** No **\_\_\_\_** If yes, what were they? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Do you have any pain, discomfort or difficulty opening your jaw / teeth? Yes \_\_\_ No \_\_\_ If yes, please describe:
**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. Do you grind / clench your teeth? Yes **\_\_\_\_** No **\_\_\_\_**
3. Do you suffer from headaches **\_\_\_**, earaches **\_\_\_**, or neck aches **\_\_\_**?
4. Have you ever had a reaction to local anesthetics? Yes **\_\_\_** No **\_\_\_.** If yes, please provide details:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. Are you happy with the appearance of your teeth? If no, please explain: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
6. Please check all that you are interested in hearing about:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * **Whitening**
 | * **Dental Implant**
 | * **Veneers**
 | * **Straightening**

**Teeth** | * **Replacing Missing**

**Teeth** |

**I understand that payment is due upon services being rendered and any balance not paid by my dental insurance is my fiscal responsibility. A monthly charge of 2% in interest will be added to any unpaid amounts.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Signature of patient or parent/guardian of a minor (MM/DD/YYYY)**