



Today's Dental Centre
We'll keep you smiling.

PATIENT REGISTRATION ALL INFORMATION IS CONFIDENTIAL
PLEASE PRINT

Date _____
M D Y

Mr. Mrs. Ms. Miss Dr. Other _____

Name: _____
(last) (first) (initial)

Address: _____
(street) (city) (province) (postal code)

Date of Birth _____ Age _____ Sex _____ S.I.N. _____
M D Y

Occupation / Employer _____

Home Telephone No. _____ Work Telephone No. _____ Email _____

Person responsible for account: Self Spouse Other If other, please complete the following:

Name _____ Telephone No. _____

Address _____
(street) (city) (province)

Family Physician _____ Telephone No. _____

Medical Specialist _____ Telephone No. _____

Do you have dental insurance? Yes No

PRIMARY DENTAL INSURANCE				SECONDARY DENTAL INSURANCE					
NAME OF INSURED		DATE OF BIRTH		NAME OF INSURED		DATE OF BIRTH			
		M	D	Y			M	D	Y
EMPLOYER				EMPLOYER					
INSURANCE COMPANY				INSURANCE COMPANY					
GROUP/POLICY NO.		DIVISION		GROUP/POLICY NO.		DIVISION			
I.D. NUMBER OR S.I.N.		CERTIFICATE NO.		I.D. NUMBER OR S.I.N.		CERTIFICATE NO.			
DEP. NO.				DEP. NO.					
COVERAGE PERCENTAGE				COVERAGE PERCENTAGE					
A	B	C	D	A	B	C	D		
LIMITS				LIMITS					
BASIC		MAJOR		BASIC		MAJOR			
DEDUCTIBLE		ORTHODONTIC		DEDUCTIBLE		ORTHODONTIC			
		<input type="checkbox"/> PER PERSON				<input type="checkbox"/> PER PERSON			
BASIC		MAJOR		BASIC		MAJOR			
		<input type="checkbox"/> PER FAMILY				<input type="checkbox"/> PER FAMILY			

In case of emergency, please notify: _____ Telephone No. _____

Relationship: _____ Telephone No. _____

Is another member of your family or relative a patient at our office? _____

Whom may we thank for referring you? _____

PLEASE TURN OVER 

MEDICAL HISTORY

Date _____
M D Y

MEDIC ALERT	
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- | | | YES | NO |
|---|---|---|--|
| 1. Are you presently under the care of a physician?
If so, explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had a medical examination in the past year? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you use any prescription or non-prescription medicine regularly?
Specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergic condition: i.e. asthma, hay fever, skin rash, food allergies? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you experienced any unusual reaction to any of the following? (please circle).....
Local Anaesthesia (freezing), Aspirin, Penicillin, Iodine, Sulfonamide (Sulfa), Barbiturates (sleeping pills),
any other medicine? If so, explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have or have you ever had any of the following? (Please check ✓) | | | |
| <input type="checkbox"/> Heart murmur or other heart condition | <input type="checkbox"/> Malignant hyperthermia | <input type="checkbox"/> AIDS | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Stomach/intestinal problems | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Positive testing for HIV virus | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Joint replacement (hip, knee, etc.) | <input type="checkbox"/> S.T.D.'s | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Mental or nervous disorder | <input type="checkbox"/> Any lung disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Hyper (hypo) thyroid | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Hyper (hypo) glycemia | <input type="checkbox"/> Arthritis or rheumatism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Scarlet or rheumatic fever | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | | <input type="checkbox"/> Cortisone/steroid therapy |
| | | | <input type="checkbox"/> Other _____ |
| | | | _____ |
| | | | _____ |
| | | | _____ |
| | | | _____ |
| 7. Has any member of your family had diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you bruise easily or bleed abnormally? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have any blood disorders such as anemia? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had radiation treatment or chemotherapy?
If so, explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had injury, surgery or x-ray therapy to your face or jaws? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have frequent earaches, ear/throat infections or any hearing difficulties? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever fainted? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you experience shortness of breath or pain in your chest when walking or climbing stairs?
If so, explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you had any organ transplants or medical implants? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Is there anything about yourself that we should be made aware of? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, explain: _____ | | | |
| 19. Women only - Are you pregnant? If so, which month are you due in? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary, as this information may be required for my dental care.

CONSENT FOR TREATMENT

I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF THE DENTAL AND ORAL SURGERY PROCEDURES THAT ARE AGREED BETWEEN MYSELF AND YOUR OFFICE TO BE NECESSARY OR ADVISABLE, INCLUDING THE USE OF LOCAL ANAESTHETIC AS INDICATED, AND WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THESE PROCEDURES AND ANY INTEREST THAT THE BALANCE MAY INCUR. INTEREST RATE 18% PER ANNUM (1.5% PER MONTH).

Patient (Parent, Guardian*) Signature: _____

If Parent or Guardian*, please print name: _____ Date _____

*Guardian of Child or Guardian of Adult under Guardianship