WELCOME TO OUR OFFICE

PATIENT REGISTRATION AND HEALTH HISTORY *MEDICAL ALERT*_____

PATIENT NAME: (FAMILY)_____ (GIVEN)_____

ADDRESS:_____ CITY:_____

PROV._____ POSTAL CODE_____ HOME PH:_____ BUS:_____

EMAIL:_____ CELL:_____

BIRTHDATE:_____ FEMALE:_____ MALE:_____

EMPLOYER:_____

REFERRED BY:_____ RELATIONSHIP:_____

IF CHILD, PLEASE COMPLETE THE FOLLOWING:

FATHER'S NAME:_____ BUS#_____ HOME#_____

MOTHER'S NAME:_____ BUS#_____ HOME#_____

WHO WILL BE RESPONSIBLE FOR ACCOUNT:_____

ADDRESS:_____ CITY:_____

PROV._____ POSTAL CODE_____ HOME PH:_____ BUS:_____

TO BE COMPLETED WITH RECEPTIONIST:

PRIMARY PLAN

INSURANCE CO:_____ GROUP#_____ DIV_____

SIN/ID#_____ SUBSCRIBER'S NAME_____ DOB_____

EMPLOYER_____

DEP#_____ PT.RELAT. TO SUBSCRIBER: SELF_____ SPOUSE_____ CHILD_____

BASIC_____ CRN/BRG_____ PROS_____ ORTHO_____

NOTES:_____

SECONDARY PLAN

INSURANCE CO:_____ GROUP#_____ DIV_____

SIN/ID#_____ SUBSCRIBER'S NAME_____ DOB_____

EMPLOYER_____

DEP#_____ PT.RELAT. TO SUBSCRIBER: SELF_____ SPOUSE_____ CHILD_____

BASIC_____ CRN/BRG_____ PROS_____ ORTHO_____

NOTES:_____

PLEASE COMPLETE MEDICAL HISTORY ON BACKSIDE

HEALTH HISTORY

	Circle
1 Are you feeling pain or discomfort at this time?	Yes No
2 Have you had a medical examination in the last year?	Yes No
3 Do you feel very anxious about having dental treatment?	Yes No
4 Have you been a patient in the hospital during the past two years?	Yes No

5 Please state your physician's name _____ Phone _____

6 Please list all medications you are on now _____

7 Are you allergic or have you reacted to any of the following medications? Please circle which ones

Aspirin	Erythromycin	Novocain	Sleeping Pills
Codeine	Local Anesthetic	Penicillin	Tetracycline
Darvon	Nembutal/Seconal	Percoidean	Valium
Demerol	Nitrous Oxide	Scopolamine	Other Antibiotics

8 Are you aware of being allergic to any other medications or substance? Yes No

9 Circle all of the following which you have

AIDS	Cortisone Medicine	Heart Pacemaker	Rheumatic Fever
Allergies/Hives	Cough	Heart Surgery	Scarlet Fever
Angina Pectoris	Diabetes	Hemophilia	Sickle Cell Disorder
Anemia	Drug Addiction	Hepatitis A (infectious)	Sinus Trouble
Artificial Heart Valve	Emphysema	Hepatitis B (serum)	Stomach Problems
Artificial Joints	Epilepsy/Seizures	Herpes	Thyroid Disease
Arthritis	Fainting/Dizzy Spells	High Blood Pressure	Tuberculosis (TB)
Asthma	Fever Blisters	HIV Positive	Ulcers
Blood Transfusion	Glaucoma	Kidney Trouble	Venereal Disease
Bruise Easily	Hay Fever	Liver Disease	X-ray/Cobalt Treatment
Cancer	Heart Disease/Attack	Lung Disease	Yellow Jaundice
Cold Sores	Heart Failure	Pain in Jaw Joints	
Congenital Heart Lesions	Heart Murmur	Rheumatism	

10 **Do you wish to speak privately to the Doctor about any medical condition?**	Yes No
11 When walking upstairs or taking a walk, do you ever stop because of pain in your chest?	Yes No
12 Do your ankles swell during the day?	Yes No
13 Have you lost or gained more then 10 pounds in the past year?	Yes No
14 Do you ever wake up from sleep short of breath?	Yes No
15 Are you on a special diet?	Yes No
16 Has your medical doctor ever said you have cancer or a tumor?	Yes No
17 Do you have a tendency to faint?	Yes No
18 Do you have frequent severe headaches?	Yes No
19 Have you had regular dental examinations (annually) in the past?	Yes No

20 If you have any disease, condition, or problem not mentioned above please list _____

FOR WOMEN ONLY Are you pregnant? Yes No If yes , what month? _____

CONSENT

The undersigned hereby authorizes doctor, upon consultation and direct consent from patient to take x-rays, study models, photographs, or any other diagnostic aid deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs I also authorize doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of Patient) _____ further to my consultation and direct consent I understand that responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements including insurance or otherwise, have been made

PATIENT/GUARDIAN SIGNATURE _____ Date _____