PATIENT REGISTRATION

PATIENT NAME		
GUARDIAN NAME		
ADDRESS		
CITY	PROVINCE	POSTAL CODE
HOME PHONE	WORK /CELL PHONE	
BIRTH DATE		
SPOUSE/ EMERGENCY CONTACT	PHONE #	
PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT		

PRIMARY INSURANCE	
EMPLOYER	EMPLOYEE
BIRTHDATE	
INSURANCE COMPANY	
GROUP #	CERTIFICATE#
BASIC %	MAJOR %
RECALL INTERVAL	HYG. UNITS/YR

SECONDARY INSURANCE	
EMPLOYER	EMPLOYEE
BIRTH DATE	
INSURANCE COMPANY	
GROUP #	CERTIFICATE#
BASIC%	MAJOR%
RECALL INTERVAL	HYG. UNITS/ YR

I authorize payment directly to my insurance company. I recognize that my dental plan may pay less than the actual bill for services and that I am financially responsible for payment in full on all accounts.

PATIENT/ GUARDIAN SIGNATURE

________________________________ DATE _____

What is your Chief Concern?____________________

____

How long has this area bothered you?__________

What are your main symptoms?____________________

____

When was your last medical check up?__________

Physician's Name________________________________

Physicians Address/Phone________________________

Have you been hospitalized / Serious illness in the past 5 Years?______________________________________

Are you allergic to any medications or drugs?______________________________________

If So, Explain____________________________________

Have you ever experienced a reaction to a dental anesthetic?________________________________

If So, Explain____________________________________

Are you pregnant or suspect you might be?____________

MEDICAL HISTORY

CHECK THE FOLLOWING

Aids	
Arthritis	
Anemia	
Asthma	
Cancer	
Diabetes	
Epilepsy	
Excessive bleeding	
Hay fever	
Heart Murmur	
Heart Trouble	
Heart splint/ valve replace	
High Blood Pressure	
Hives	

Hepatitis A	
Hepatitis B	
Hepatitis C	
Joint Replacement hip/knee)	
Jaundice	
Kidney Condition	
Liver Condition	
Psychiatric Therapy	
Radiation Therapy	
Rheumatic Fever	
Stroke	
Thyroid Condition	
Tuberculosis	
Venereal Disease	

Do you have any medical condition not listed above that we should know about?________________________

____

LIST MEDICATIONS:

____

____

____

____

____

Last Dental Visit?

____

Do your gums ever bleed?________________

Is your mouth sensitive to pressure, hot, or cold?_______

Is There anything else your DENTIST should be aware of?

____

____

____

MEDICAL HISTORY UPDATES

DATE	COMMENTS

Date	Notes