KING STREET DENTAL CENTRE
Creating Beautiful Smiles

Registration Information

Monday, May 01, 2017

The information that is requested on this questionnaire is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to a collecting, using and disclosing this information responsibly. PLEASE PRINT.

The patient is an Adult ○ Child ○ Adult under Guardianship ○ Guardian Name:

Dr ○ Mr ○ Mrs ○ Ms ○ Miss ○ Referred by

First Name Last Name

Address City Province Ontario Postal Code

Birth Date: Month: Day: Year: Age Sex Martial Status

Work Phone: May call you at work? Yes ○ No ○ Employer:

Home Phone: Cell Phone: Email:

Personal responsible for account: Name of spouse:

Address:

If you have insurance, please provide details:
Company: Policy/Cert:# (if required by office)

Additional registration information if required by office:

Family Physician Firstname: Last Name: Phone:

If you are under the care of medical specialist then provide full name: Phone:

In case of emergency please contact: Phone: Relationship:

Health History	Yes	NO
Are you being treated for any medical condition at present or within the past year? If YES, please explain:	○	○
Has there been any change in your general health in the past year?	○	○
When was your last visit to a physician?____ Last complete physical examination?	○	○
Have you recently, or are you presently, taking any PRESCRIPTION or NON-PRESCRIPTION drugs? (including herbal remedies) If yes, please list:	○	○
Have you ever had any adverse or unusual reacting to any medications or injections? (eg: penicillin, or other antibiotics, aspirin, codeine, local anesthetic ("dental freezing")? Please explain:	○	○
Have you ever been advised against taking any specific type of medication?	○	○
Do you have any allergies? (e.g: hay fever, food allergies, latex/rubber or metal allergies?	○	○
Do you have epilepsy or seizures?	○	○

Have you ever fainted during dental or medial treatment?

Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders? Please explain:

Are you on any cortisone or steroid therapy, or, are you on a diet pill therapy?

Do you have any artificial joints? (hip, knee)

Have you ever been advised to take antibiotics before dental treatment?

Do you have, or have your ever had any heart of blood pressure problems? (heart attack or stroke) Please explain:

Do you have a heart murmur, valve dysfunction (mitral valve prolapsed or antificial heart valve) or have your ever had Rheumatic Fever?

Do you have or have your ever had any chest pain, shortness of breath or any heart palpitation without exertion?

Are you presently suffering from any infectious diseases?

Have you ever had Hepatitis, Jaundice or any liver disease? Please explain:

Do you have any condition that could effect your immune system? (ex: arthritis, AIDS, HIV infection, lupus, inflammatory bowel disease, Crohn's disease?) Please specify:

Have you ever had any malignant disease, or are you presently undergoin any radiation treatment/chemotherapy?

Indicate which of the following you presently have or ever had: Please check

☐ Asthma	☐ Tuberculosis	☐ Glandular Disorders
☐ Bronchitis	☐ Diabetes	☐ Organ Transplant/Medial Implant
☐ Emphysema	☐ Kidney Disease	☐ Stomach/Intestine Problems
☐ Lung Disease	☐ Thyroid Disease	☐ Ulcers

Do you, or did you smoke? Do you drink alcoholic beverages on a regular basis? Use recreational drugs?

Are there any diseases or medical problems that run in your family? (ex: diabetes, cancer, heart disease)

Do you currently have, or ever had in the past, any disease, condition or problem not listed above?

Is there anything else about your health we should be made aware of; or do you wish to speak to

doctor privately about any problem or medical condition?

WOMEN ONLY:

Are you taking birth control pills? ☐ Yes

Are you breast feeding? ☐ Yes

Are you pregnant? ☐ Yes

Expected delivery date?

Women over 50 ☐ Yes

DENTAL HISTORY	YES	NO
Is there a dental problem you would like treated immediately	○	○
Date of your last dental visit? Last dental cleaning? Last x-rays?	○	○
How often do you brush your teeth? Do you feel you have had breath?	○	○
Do you use dental floss? Proxabrush? Stimudents? How often?	○	○
Are you teeth sensitive to heat ☐, cold ☐ or sweets ☐?	○	○

Have you ever had the following:

Periodontal treatment? (treatment of the gums)	☐ Yes
Orthodontic Treatment?	☐ Yes
A bite plate or any other appliance?	☐ Yes
Bite Adjustment?	☐ Yes
Oral surgery? (Surgery in or about the mouth jaw joint, or implant surgery)	☐ Yes

Do you have any emotional concerns about having dental treatment?	○	○
Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment?	○	○
Are you unhappy with the appearance of your teeth?	○	○
What would you like to see changed?	○	○
Do you feel your dental health influences your overall health?	○	○
On a scale of 1 to 10 being highest, how important is it for you to keep your natural teeth?	○	○

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical dental history. Should there any change in either my health status or any other information I have provided I will advice the dental office. I authorize the dentist to perform diagnostic procedure as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy, policy of the office and that my personal information will be collected, used and

disclosed within the guidelines of the policy. I understand that responsbili8ty for payment of the dental services for myself and my dependents in mine and I assume responsibility for fees associated with these services.

Signature of ○ Patient ○ Parent ○ Guardian

(Full Name)

Date:

Reviewed by treating dentist: