

**WELCOME TO ST. CATHARINES DENTAL CENTRE
REGISTRATION INFORMATION**

Date: _____

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form.

REGISTRATION INFORMATION

The patient is an: Adult Child Adult under guardianship

Name of Guardian: _____

Name: Last, First: _____ Initial: _____ Dr. Mr. Mrs. Ms Miss

Address: Street _____ Address: Street 2 _____

City and Prov/State: _____ Zip/Postal code: _____

Reason for today's visit? Examination Emergency Other _____

Is there a dental problem you would like treated immediately? _____

Preferred appt. time? _____

Home Phone: _____ Cell Phone: _____ Pager No: _____

Bus Phone: _____ Ext: _____ Employer: _____

Email: _____ May we call you at work? Yes No

Prefers to be called: _____ Occupation: _____

Date of Birth: M: _____ D: _____ Y: _____ Age: _____

Marital Status: _____ Name of Spouse: _____

Are other family members patients of our office: Yes Names: _____

Whom may we thank for referring you? _____

Family Physician: _____ Phone: _____

Medical Specialist: _____ Phone: _____

In case of an emergency please contact: _____ Phone: _____

Pharmacy Information: _____ Phone: _____

Health Card # _____

FINANCIAL & CREDIT INFORMATION

Person responsible for account:

Self Spouse Other

Name: First, Last _____

Initial _____ Home Phone: _____

Address Street: _____

Address Street 2 _____

City and Province: _____

Zip/Post Code: _____

Employed By: _____

Phone: _____

Credit Card No: _____

Expiry Date: _____

Primary Dental Insurance:

Subscriber's Name: _____

D.O.B. _____

Emp/Grp. Policy Holder: _____

Ins Yr End: _____

Ins Co. _____

Tel: _____

Grp/Ind Policy No. _____

Cert No. _____

Secondary Dental Insurance:

Subscriber's Name: _____

D.O.B. _____

Emp/Grp. Policy Holder: _____

Ins Yr End: _____

Ins Co. _____

Tel: _____

Grp/Ind Policy No. _____

Cert No. _____

DENTAL HISTORY

Dental History: Please check Yes or No to each question. If unsure of a question, consult the dentist.

Is there a dental problem that you would like treated immediately? Yes No _____

Date of your last dental visit? _____

Last Dental Cleaning? _____ Last x-rays _____

Are you having regular dental visits? Yes No

Periodontal Treatment (treatment of gums?)

Orthodontic Treatment (to straighten or realign teeth)?

A bite plate or any other appliance?

Oral Surgery (Surgery in or about the mouth/jaw joint or implant surgery).

How often do you brush your teeth? _____

Do you feel that you have bad breath? Yes No

Do you use dental floss, proxbrush or stimudents?

How often? _____ Yes No

Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of our gums? Yes No

Does food catch between your teeth?

Yes No

Are any of your teeth sensitive to heat, cold, sweets or pressure? Yes No

Have you ever experienced any of the following jaw problems?

Popping/clicking in your jaw joints?

Yes No

Pain in your jaw joints around your ear, or side of your face?

Yes No

Difficulty with opening or closing?

Yes No

Pain when teeth are clenched? Yes No

Pain or difficulty when chewing? Yes No

Do you have the following habits?

Clenching or grinding your teeth while awake or asleep? Yes No

Biting your cheeks or lips? Yes No

Mouth breathing while awake or asleep? Yes No

Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? Yes No

Do you have any emotional concerns about having dental treatment? Yes No _____

Are you unhappy with the appearance of your teeth?

What would you like to see changed? _____

Have you ever had an upsetting experience in the dental office, or any complications during or following dental treatment, or do you have any questions or concerns? _____

HEALTH HISTORY

Are you being treated for any medical condition right now or within the last year? Yes No

If yes please explain: _____

Has there been any change in your general health within the past year? Yes No

When was the last visit to your Physician? _____ Last complete physical examination? _____

List any PRESCRIPTION or NON-PRESCRIPTION drugs you are taking or have recently taken (including birth control pills):

Have you ever had any adverse or unusual reaction to any medications or injections? (e.g. penicillin, or other antibiotics, aspirin, codeine. local anesthetic ("dental freezing"))? Yes No Please explain:

Have you ever been advised against taking any specific type of medication? Yes No _____

Do you have any allergies (e.g. hay fever. food allergies, latex/rubber or metal allergies)? Yes No

Have you ever fainted during dental or medical treatment? Yes No

Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders? Yes No Please explain:

Are you on cortisone or steroid therapy, or, are you on a diet pill therapy? Yes No

Do you have any artificial joints (e.g. hip, knee)? Yes No _____

Have you ever been advised to take antibiotics before dental treatment? Yes No _____

Do you have a heart murmur, valve dysfunction (mitral valve prolapse or artificial heart valve) or have you ever had Rheumatic Fever? Yes No

Do you have, or have you ever had. any heart or blood pressure problems (heart or stroke)? Yes No Please explain:

Do you have or have you ever had any chest pain, shortness of breath or any heart palpitation without exertion? Yes No

Are you presently suffering from any infectious diseases? Yes No

Do you have any condition that could affect your immune system (e.g. arthritis, AIDS, HIV infection, lupus, inflammatory bowel disease, Crohn's disease)? Yes No Please specify: _____

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

Indicate which of the following you presently have, or ever had: (Please check all that apply)

- | | | | |
|---------------------------------------|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Glandular Disorders |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Organ Transplant/Medical Implant |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach/Intestinal Problems |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Ulcers |

Do you, or did you smoke? Yes No

Do you drink alcoholic beverages on a regular basis? Yes No

Use Recreational Drugs? Yes No

WOMEN ONLY: Are you pregnant? Yes No

If pregnant, delivery date? _____

Are you breast feeding? Yes No

Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer, heart disease)? _____

Do you currently have, or ever had in the past, any disease, condition or problem not listed above? Yes No

Is there anything else about your health we should be made aware of: or do you wish to speak to the doctor privately about any problem or medical condition? _____

NOTES: _____

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 be any change in my health status in the future, I will advise this dental office. I authorize the dentist to perform diagnostic procedures 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, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

(signature) Patient Parent Guardian

(print name of guardian)

Reviewed by Treating Dentist: _____

Date: _____

OFFICE POLICY

So that we may maintain the operation of our office on sound principles and assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to definite arrangements of appointments and fees. Once you have made your appointment, please remember that this time is reserved for you. Therefore **AT LEAST 48 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY, OTHERWISE THE USUAL FEE CHARGE WILL BE APPLIED.** Also, there will be a **5% finance charge** on all unpaid balances over 30 days.