WELCOME TO ST. CATHARINES DENTAL CENTRE
REGISTRATION INFORMATION

Date: _____ PID # _____

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: _____

FINANCIAL & CREDIT INFORMATION

Person responsible for account: Self ☐ Spouse ☐ Other ☐

Name: First, Last _____ Initial _____ Home Phone: _____

Address Street: _____ Adress Street 2 _____

City and Province: _____ Zip/Post Code: _____

Employed By: _____ Phone: _____

Driver's Lic No: _____ S.S.N _____

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)

☐ Asthma	☐ Epilepsy or Seizures	☐ Tuberculosis	☐ Glandular Disorders
☐ Bronchitis	☐ Hepatitis	☐ Diabetes	☐ Organ Transplant/Medical Implant
☐ Emphysema	☐ Jaundice	☐ Kidney Disease	☐ Stomach/Intestinal Problems
☐ Lung Disease	☐ Liver Disease	☐ Thyroid Disease	☐ 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. 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: _____