## DENTALZEN

# REGISTRATION FORM

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|  |
| PATIENT INFORMATION |
| Patient’s Last Name: | First: | Middle: | ❑ Mr.❑ Mrs. | ❑ Miss❑ Ms. | Gender  |
|  | Male / Female / Other |
| Dental Insurance  | Email Address: | Who is legally responsible for this account:  | Date Of Birth: |
| Yes | No |  |  |  / /MM / DD / YYYY |
| Street address: | Cell Phone #: | Home Phone #: |
|  | ( ) | ( ) |
| Emergency Contact: | City: | Province: | Postal Code: |
|  |  |  |  |
| Emergency Contact Phone #: | Health Card Number: | Pharmacy Phone #: (if known) |
|  |  | ( ) |
| Referred to clinic by (please check one box): ❑ Google |  ❑  | Facebook | ❑ Family/Friend |  |
| ❑ Flyer |  |  ❑ Close to home/work |  ❑ Door Hanger |  ❑ Other  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Weight: \_\_\_\_\_KG |
|   |
| Dental history |
| Previous Dentist: Phone number: |
| 1. When was your last dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. How often do you have a dental check up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3. Have you ever had an unfavorable experience at the dentist? .…...……………………………………...…..…. Yes…...No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4. Do you have any discomfort in your teeth due to hot, cold, sweets, biting, or chewing pressure?...................Yes…...No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_5. Does food catch between your teeth? If so where?..........................................................................................Yes…...No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6. Do your gums bleed when brushing or flossing?..............................................................................................Yes...…No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_7. Are you conscious of bad breath or bad taste in your mouth?..........................................................................Yes…...No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_8. Do you favour one side when chewing?...........................................................................................................Yes…...No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_9. Are you unhappy with the appearance of your teeth, bite or smile?.................................................................Yes...…No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_10. If you could, would you change anything about your smile?...........................................................................Yes...…No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_11. Do you consider your teeth beyond repair?.....................................................................................................Yes...…No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_12. Do you ever wake up with a headache or have a tired feeling in your face or jaws?......................................Yes...…No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_13. Do your jaw joints pop, click or grate when opening widely?...........................................................................Yes...…No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_14. Do you clench or grind your teeth?..................................................................................................................Yes..….No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 15. Have you lost any teeth due to abscess, accident, and decay or gum disease? (please circle)……..……….Yes.......No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_16. Was tooth replacement suggested?................................................................................................................Yes……No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| medical history |
| Physician:  | Address: | Phone no.: |
|  |  |  |
| Are you currently under any medical treatment? If so, for what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Have you had an allergic or unusual reaction to: (Please circle your answer to each question. If yes, please explain)

Aspirin Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cosmetics Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Codeine Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Metals Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Anesthetic Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Medicines Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Penicillin Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Woman: Are you pregnant Yes No Due Date: \_\_\_\_\_\_\_\_

Do you have any other allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated for any of the following:

AIDS/HIV…………… Yes No Glaucoma………. Yes No Pain in the Chest………. Yes No

Anemia……………… Yes No Hay Fever………. Yes No Persistent Cough………. Yes No

Anorexia or Bulimia… Yes No Heart Defects….. Yes No Rheumatic Fever………. Yes No

Arthritis……………… Yes No Heart Murmurs… Yes No Rheumatic Arthritis…….. Yes No

Asthma……………… Yes No Heart Trouble….. Yes No Seizures………………… Yes No

Bleeding Problems… Yes No Hemophilia…….. Yes No Sinus Trouble…………... Yes No

Blood Disorder/Problems Yes No Hepatitis A, B or C Yes No Liver Disease…………… Yes No

Bowel Problems…… Yes No High Blood Pressure Yes No Skin Disorder…………… Yes No

Cancer……………… Yes No Jaundice………… Yes No Stroke…………………… Yes No

Coughing up Blood… Yes No Kidney Problems.. Yes No Thyroid Problems……… Yes No

Diabetes…………….. Yes No Leukemia………… Yes No Tuberculosis……………. Yes No

Drug/ Alcohol Dependency Yes No Liver Problems….. Yes No Ulcer…………………….. Yes No

Emphysema………… Yes No Lung Disease…… Yes No Venereal Disease……… Yes No

Epilepsy……………… Yes No Lupus…………….. Yes No Other……………………. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gastrointestinal Disease Yes No Mitral Value Prolapse Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever been hospitalized or had a serious illness or had any surgery?................................ Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Are you or have you received any psychiatric care and are you receiving medication for this?....... Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Are you being treated for any condition by a physician? ………………………………………………. Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 A. presently? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 B. in the last 2 years? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Have you taken any drugs, pills, medicines or tablets in the last 2 years? …………………………. Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Do you ever have asthma, hayfever, hives or skin rash? …………………………………………….. Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Have you ever had an adverse reaction to any drug including local anesthetic or general anesthesia? …… Yes No \_\_\_\_\_\_\_\_\_

7. Are you allergic to latex? …………………………………………………………………………………. Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have you had any unexplained weight loss, increasing thirst or appetite, frequency of urination? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Have you ever taken cortisone? ……………………………………………………………………….... Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Do you bleed for a prolonged period of time when cut? …………………………………………….. Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Do you have any problems with healing when cut or bruised? ……………………………………... Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Is there any history of disease in your family? ………………………………………………………... Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Have you ever fainted? ………………………………………………………………………………….. Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Is there anything that the dentist should know about your medical history that hasn’t been mentioned? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. Are you pregnant or nursing? ………………………………………………………………………….. Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. Are you presently taking any drugs or medicines? (please circle) …………………………………. Yes No

 Antibiotics or Sulfa Drugs Drugs for heart trouble Sedatives or sleeping pills

 Anticoagulants (blood thinners) High Blood Pressure Medicine Tranquilizers

 Antidepressants Insulin, Diabinese or similar drugs Water Pills

 Cortisone Nitroglycerin Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. Have you had any joint replacements? ………………………………………………………………. Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. Have you ever or are you now receiving radiation therapy or chemotherapy? ………………….. Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19. Do you have any in-dwelling catheters? ……………………………………………………………... Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20. Have you ever taken appetite suppressant drugs, for example fenfluramine, phentermine or dexfenfluramine?

 Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21. Are you suffering from Sleep Apnea? Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

22. Do you smoke?..............................How much? …………………………………………………….. Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23. Have we missed anything? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This is to certify that I, the undersigned, consent to the performing of Dental and Oral surgery procedures agreed to be necessary or advisable including the use of local anesthetic and/or relative analgesia as indicated, and I will assume responsibility for fees associated with those procedures.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Patient’s (Parent/ Guardian) Signature* *Date*