Martensville Dental Clinic

Welcome to our office

THERAPEUTIC ALERT

All information is confidential

PATIENT REGISTRATION

Date of Birth______/______/______
D M Y

Name____ **Male** **Female**
last first

Mailing Address____
PO Box city/town province postal code

Telephone: Residence________________________ **Business**___________________ **Cell**_______________________

E-MAIL_____________________________**Occupation** _____________________ **HOSP #** ________________________

Spouse/Parents Name____________________________________ **Daytime Telephone**_________________________

Emergency contact person (other than spouse/parent)__________________________ **Telephone**______________

Person responsible for account Self Other Person____

Whom may we thank for referring you?____

INSURANCE INFORMATION

Dental Insurance: Yes No Employer of Insured_____________________ **Insurance Name**________________

Group Policy #_________________ **Certificate** #______________________ **Name of Insured**____________________

Treaty #_______________________ **Date of Birth**______/______/_______
D M Y

MEDICAL HISTORY

Family Physician____ **Telephone**_____________________

Medical Specialist____ **Telephone**_____________________

1. **Have you ever had a serious illness requiring hospitalization or extensive medical care?** …… **Yes No**

   Specify____

2. **Are you now under the care of a physician or specialist?** ……………………………………………………………. **Yes No**

   Specify____

3. **Are you presently taking any kind of medication?**………………………………………………………………………. **Yes No**

   Specify____

4. **Do you have an allergic condition? i.e. asthma, hay fever, latex allergy** ………………………………… **Yes No**

5. **Have you ever had an unusual reaction to any of the following? (please circle)**

   local anesthesia (freezing) **codeine** **latex** **erythromycin**
   penicillin **sulfa drugs** **tetracycline** **aspirin**

   other medications ____

6. **Were you ever told that you require preventative antibiotics before dental procedures?** ……. **Yes No**

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7. Have you ever had any injury, surgery or radiation therapy to your face or jaws? .... Yes No

8. Do you smoke or chew tobacco? How much?____________ Number of years?_________ No

9. Are you pregnant? .... Yes No

10. Do you take birth control pills? .... Yes No

11. Do you have or have you ever had any of the following? (please circle)

heart murmur or other heart condition	**back pain**	**hemophilia**
stomach/intestinal problems	**kidney trouble**	**liver disease**
joint replacement (hip, knee)	**cancer**	**alcohol/drug addiction**
mental or nervous disorder	**stomach ulcers**	**epilepsy**
high/low blood pressure	**radiation therapy**	**fainting or dizzy spells**
hyper/hypo glycemia	**chemotherapy**	**jaundice**
arthritis	**glaucoma**	**sinus trouble**
scarlet or rheumatic fever	**leukemia**	**stroke**
tuberculosis	**thyroid disease**	**heart attack**
heart pacemaker	**HIV (+), AIDS**	**any lung disease**
blood clotting problems	**hepatitis B/C**	**malignant hyperthermia**
diabetes		

Any condition or illness not listed____

DENTAL HISTORY

1. What dental condition concerns you at present?____________________________________

2. How frequently do you visit a dentist? 6 months yearly other______________________

Last dental visit________________ **Last cleaning**______________________________

3. Former dentist______________________

4. Are any of your teeth sensitive to: hot cold sweets biting pressure other____________

5. How often do you brush your teeth?__________________ **Floss?**____________________

6. Do your gums bleed when: brushing flossing spontaneously

7. Do your gums feel tender or swollen? .... Yes No

8. Does food catch between your teeth? (persistently) .... Yes No

9. Does your jaw joint click, pop or lock when opened widely? .... Yes No

10. Do you clench or grind your teeth? .... Yes No

11. Have you ever had any of the following?

orthodontics	**oral surgery**	**periodontal treatment**
dentures	**night guard**	**bite adjustment**

12. Are you nervous about receiving dental treatment? .... Yes No

13. Would you rate your dental health as: excellent good fair poor

14. Are you happy with the appearance of your teeth? very fairly no

15. Is there anything that you would change?____

16. Have you had any dental problems you think the dentist should know about?________________

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continue ⇒

CONSENT FOR DENTAL TREATMENT AND USE OF PERSONAL INFORMATION FOR DENTAL CARE

Recent government regulation requires us to obtain your consent to collect and use your personal information for your dental care.

I, the undersigned, certify that all the medical information provided is true to the best of my knowledge and I have not omitted any pertinent information.
I also consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic or sedation as indicated, and I will assume responsibility for fees associated with these procedures performed. I further agree to let the dentist know if my medical status changes.

I consent to the collection, use and disclosure of my personal information for the following purposes: (check boxes)

To provide me with dental health services;
To maintain communications and provide me with information and follow up respecting my dental care;
To obtain payment of my account.

Privacy Restrictions (If any applicable):____

Patient (Parent/Guardian) Signature____ **Date** _____/_____/_____
D M Y

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MEDICAL HISTORY UPDATE (office use only)

Date	No change	Change	Dr. Init.	Pt. Init.