Registration Form

Welcome to our office! Thank you for taking the time to fill out these important documents. We look forward to getting to know you better!

PATIENT NAME: Mr./Mrs./Miss/Ms/Dr _____
DATE OF BIRTH (Day/Month/Year): _____ M ☐ F ☐

ADDRESS: _____POSTAL CODE: _____

RESIDENCE PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ OCCUPATION: _____

EMAIL ADDRESS: _____

☐ I consent to having email/reminders sent to me.

PATIENT'S PARENTS/GUARDIAN/OR SPOUSE: _____

DATE OF BIRTH (Day/Month/Year): _____PHONE NUMBER: _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY: NAME: _____

RELATIONSHIP: _____ PHONE: _____

NAME OF DOCTOR: _____ PHONE: _____

NAME OF INSURANCE COMPANY (IF APPLICABLE): _____

How did you hear about our office? Check all that apply. FLYER☐ LOCATION☐ WEBSITE ☐

BILLBOARD ☐ FACEBOOK ☐ GOOGLE REVIEW☐ REFERRAL (By whom) _____

Due to privacy and confidentiality matters insurance companies provide dental providers with little information. Please be prepared and/or aware of your dental coverage, as it is the ***PERSONAL RESPOSIBILITY OF THE PATIENT***. **Any portion not covered by your plan is *YOUR* responsibility when the treatment is rendered. We will help prepare necessary reports to submit to assist you to collect your benefits from insurance companies. A credit card number may be requested to reserve your appointment time. However, our treatment plans are based on individual patient needs and preferences, and not primarily on whether the dental treatment is covered by insurance.**

APPOINTMENTS: Appointment times are reserved for you. If you are unable to keep an appointment, please give us at least 2 business days notice to make alternate scheduling arrangements, or a cancellation fee may apply.

PRIVACY: I understand that the required standards of personal information confidentiality are being met in accordance with the Health Professionals Act and the Alberta Personal Information Protection Act.

☐ I have read and understand the above conditions and content.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN: _____DATE: _____

MEDICAL HISTORY QUESTIONAIRE *MEDICAL ALERT* _____

The following information is required to enable us to provide you with the best possible dental care. All information is private and protected by doctor-patient confidentiality.

1. Have you ever required extensive medical care or been HOSPITALIZED for any illness or operation?

   _____

2. Are you being treated for any medical condition at the present time? _____
3. When was your last medical checkup? _____
4. Have there been any significant changes in your GENERAL HEALTH or in your WEIGHT in the past year?

   _____

5. Are you presently taking any MEDICATIONS, non-prescription drugs or herbal supplements of any kind?

   _____

6. Do you have any ALLERGIES?
   a) Medication/Anesthetic allergy: _____
   b) Latex/Rubber products allergy: _____
   c) Other: _____
7. Do you have a PROSTHETIC or artificial joint, organ transplant or medical implant?

   _____

8. Have you ever been advised by your doctor to take ANTIBIOTICS before dental treatment? Y/N
9. Do you have any conditions or therapies that could affect your IMMUNE SYSTEM eg . Leukemia, Steroid Therapy, AIDS, HIV infection, Radiotherapy, Chemotherapy? _____
10. Have you ever had Hepatitis A, B, C, Jaundice or Liver Disease? _____
11. Do you have or have you ever had a Bleeding disorder, anemia, clotting problem or bruise easily?

    _____

12. Do you have or have you ever had any of the following?

☐ Chest Pain, Angina	☐ Prosthetic Heart Valve	☐ Tuberculosis	☐ Seizures
☐ Heart Attack	☐ Venereal Disease/STD	☐ Steroid Therapy	☐ Arthritis
☐ Stroke	☐ Mental/Nervous Disease	☐ Diabetes	☐ Epilepsy
☐ Thyroid Disease	☐ Drug/Alcohol Dependency	☐ Stomach Ulcers	☐ Cancer
☐ Kidney Disease	☐ Pacemaker	☐ Shortness of Breath	☐ Lung Disease
☐ Multiple Sclerosis	☐ Numbness in Hands	☐ Diet Pill Therapy	☐ Migraines
☐ Faint Easily	☐ Smoke or chew Tobacco		

For Women only: Are you pregnant, or think you might be, or nursing a baby? If pregnant, when is the expected delivery date? _____

PATIENT SIGNATURE: _____ DATE: _____

RELIANCE DENTAL

DENTAL HISTORY FORM

When was your last dental visit? _____ Treatment done? _____
When was your last panoramic x-ray taken? _____
Please rate your dental health. Excellent ☐ Good ☐ Fair ☐ Poor ☐
Is there a dental problem that you would like to take care of as soon as possible? If Yes – Please indicate:
_____
Have you ever had a raised bump or sore spots in your mouth? Yes ☐ No ☐
If yes, how long was it present? _____
How is your sugar intake? ☐ High ☐ Medium ☐ Low
Have you been given oral hygiene instruction in:
☐ Re mineralizing Agents ☐ Spin/Power Brushing ☐ Flossing ☐ Mouth rinses
Do your gums bleeding when: ☐ Brushing ☐ Flossing ☐ Eating ☐ Never

Do you breathe through your mouth more than your nose:	Yes	No
Do you snore?	Yes	No
Do you get frequent or severe headaches?	Yes	No
Do your teeth experience sensitivity to hot or cold temperatures?	Yes	No
Does food get caught between your teeth?	Yes	No
Do you have any loose teeth?	Yes	No
Do you grind or clench your teeth?	Yes	No
Does any part of your mouth hurt when clenched?	Yes	No
Does your jaw crack, pop, when you open/close?	Yes	No
Do you have any difficulty opening or closing your jaw?	Yes	No
Are your wisdom teeth still present?	Yes	No
Do you gag easily?	Yes	No
Would you like your teeth whitened?	Yes	No
Are your front teeth aligned ideally to the way you would like?	Yes	No
Overall, are you happy with your smile?	Yes	No

If you could change your smile, what would you change? _____
Have you ever had any of the following? Please circle.
☐ Braces ☐ Bite Adjustment ☐ Night Guard or Other Appliances ☐ Injury to Teeth or Jaws
☐ Crowns or Bridges ☐ Dental Implants ☐ Gum Surgery ☐ Wisdom Teeth Removed
☐ Oral Surgery ☐ Root Canal Therapy ☐ Denture ☐ Sports Guard
Do you have any concerns regarding your dental visit? Please specify. _____

PATIENT SIGNATURE: _____ DATE: _____