NEW PATIENT REGISTRATION

To help us provide better care please fill out both sides of this form carefully.

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Today's Date ____________

Name ____________ Birth Date (DD/MM/YR) ____________ Age ____________

Address ____________ Apt. ____________

City ____________ Postal Code ____________ E-mail ____________

Telephone ____________ Cell ____________

Occupation ____________ Employer ____________

Work Address ____________ Work Telephone ____________

Driver's Licence Number ____________ Social Insurance Number ____________

Spouse's Name ____________ Spouse's Work Telephone ____________

Do you have Dental Insurance? YES NO If yes, please provide receptionist with particulars.

What attracted you to our office? ____________ Whom may we thank for referring you? ____________

Child Registration

Father's Name ____________ Employer ____________ Telephone ____________

Mother's Name ____________ Employer ____________ Telephone ____________

Dental History

Are you happy with your smile? ____________

What would you like to change? ____________

Are you experiencing any dental discomfort? ____________

What is the reason for your visit today? ____________

Name of previous Dentist ____________ Address ____________

Telephone ____________ When was your last dental visit? ____________

When was your last cleaning? ____________ Were x-rays taken? ____________

FOR DOCTOR'S USE ONLY

Date	Treatment	Amount

Medical History

Name of Family Doctor ______________________ Telephone ______________________

Have you had a serious illness or have been hospitalized in the last 5 years? ______________________

If yes, please state reason ______________________

Are you pregnant? ______________________ If yes, how many weeks? ______________________

Are you taking any medications? ______________________

Are you allergic to any of the following?

	YES	NO		YES	NO
Penicillin	☐	☐	Nitrous Oxide	☐	☐
Erythromycin	☐	☐	Local anesthetic	☐	☐
Tetracycline	☐	☐	Codeine	☐	☐
Other ______	☐	☐	Aspirin	☐	☐

Do you have or did you ever have any of the following?

	YES	NO		YES	NO
Heart Disease	☐	☐	Hepatitis	☐	☐
High Blood Pressure	☐	☐	Rheumatic Fever	☐	☐
Lung Disease	☐	☐	Diabetes	☐	☐
Kidney Disease	☐	☐	Liver Disease	☐	☐
Asthma	☐	☐	Epilepsy	☐	☐
Heart Murmur	☐	☐	Ulcers	☐	☐
Arthritis	☐	☐	Cancer	☐	☐
Stroke	☐	☐	Venerial Disease	☐	☐
HIV / Aids	☐	☐	Fainting	☐	☐
Hemophelia	☐	☐	Psychiatric Treatment	☐	☐

Do you have any other medical problems? If yes, please state. ______________________

Acknowledgement and Authority

I consent to treatment as necessary for my health.
I certify that the information above is correct.
I acknowledge that there will be a charge for appointments missed or cancelled without at least 48 hours notice or sufficient reason.
I acknowledge that I am responsible for the payment of services provided and agree to pay for them in full at the end of each appointment unless other arrangements are made in writing with the receptionist.

____

Signature Date

Medical Update

Date	Remarks	Patient Initials