Date_____

THAMES RIVER FAMILY DENTISTRY

REGISTRATION INFORMATION

MEDICAL ALERT	

The information that is requested in this questionnaire is essential to provide you with the highest standard of dental care. We commit to protect your privacy and use the information responsibly. We appreciate the confidence you place with us to provide dental services. Please complete the following.

Patient is an: ADULT ◯ CHILD ◯ ADULT UNDER GAURDIANSHIP ◯ Name of the Guardian: _____

Dr. ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss. ◯ Referred by: _____

Name: First Middle Last Birth Date: M_____D_____Y_____

Address: Street Apt # Phone: HOME – (____) _____

BUSINESS – (____) _____

City Postal code EMAIL ID: _____

Age _____ Sex _____ Marital Status _____

Person responsible for account: _____ Name of Spouse: _____

Employer: _____ Do you have insurance: Yes ◯ No ◯

Insurance Company: _____ Policy/Certificate # _____

MEDICAL HISTORY

	YES	NO
1. When was your last visit to the physician? _____ Last complete examination _____		
2. Have there been any changes in your general health in the past year? _____	☐	☐
3. Are you being treated for any medical condition at present or within the past year? If yes, please explain _____	☐	☐
4. Have you recently, or presently, taken any PRESCRIPTION or NON-PRESCRIPTION medication? Please list all the medications: _____	☐	☐
5. Allergies or UNUSUAL reaction to any medication or injections. Please explain: _____	☐	☐
6. Do you have any other allergies? (e.g. Food, Latex, Metal, Hay fever) _____	☐	☐
7. Are you suffering from epilepsy or do you have seizures? _____	☐	☐
8. Do you bleed excessively from a cut or minor injury or bruise easily or have any blood disorders?_____ Please explain: _____	☐	☐
9. Do you have artificial joints? (E.g. Hip, Knee) _____	☐	☐
10. Do you take PRE-MEDS (antibiotics) before dental treatment? _____	☐	☐
11. Do you have or ever had any heart or blood pressure problems? (e.g. Chest pain, Heart attack, Heart murmur, Shortness of breath, Heart valve problem, Rheumatic fever, Pacemaker, Artificial valve) _____	☐	☐
12. Are presently suffering from any infectious disease? _____	☐	☐
13. Have you ever had Hepatitis, Jaundice or any other Liver disease? _____	☐	☐
14. Do you have any condition that could affect your immune system? (e.g. AIDS, HIV, Lupus, Infectious bowel Disease, Crohn's disease) _____	☐	☐
15. Have you ever had any malignant disease, or are you presently undergoing radiotherapy / chemotherapy? (E.g. Cancer, Tumor) _____	☐	☐

16. Do you smoke _____ Do you drink alcoholic beverages on a regular basis? _____ **YES** **NO**
Do you use recreational drugs? _____

17. **Please circle** which of the following you presently have, or ever had:

Tuberculosis		Emphysema	Asthma	Bronchitis
Diabetes	Thyroid disease	Organ transplant	Stomach / Intestinal problems	Kidney disease
Stroke		Glandular disorder	Blood transfusion	Arthritis

18. Are there any diseases or medical problems that run in your family? (e.g. Diabetes, High blood pressure, Cancer)
_____

19. Do you currently have, or ever had any disease / condition / problem that is not listed above?
_____

20. Is there anything else about your health that we should be aware of? _____

21. WOMEN ONLY
Are you taking birth control pills? _____ Are you pregnant? _____ Are you breastfeeding? _____
Expected delivery date _____ Have you reached menopause? _____

DENTAL HISTORY

1. Is there a dental problem that you would like to treat immediately? _____
2. Your last dental visit _____ Last x-rays taken _____
3. How often do you brush your teeth? _____ Do you have bad breath? _____
4. Do you floss your teeth? _____
5. Are your teeth sensitive to Hot / Cold / Sweet? _____
6. Have you ever had (PLEASE CIRCLE):

(i) Periodontal treatment (gum surgery) *(ii) Orthodontic treatment (braces)* *(iii) Oral surgery* *(iv) Dental Implants*

7. Have you ever had an upsetting experience in a dental office? (during or after the appointment) _____
8. Do you have emotional concerns about having dental treatment? _____
9. Are you happy with the appearance of your teeth? _____
10. What would you like to see changed? _____
11. Do you believe that your dental health influences your overall health? _____
12. On a scale of 1 – 10, 10 being the highest, how important is it for you to keep your natural teeth? _____

NOTES: _____

I, certify that as requested I have provided my most accurate and complete medical / dental history. If there are any changes in my health status, I take responsibility to inform the dental office. I understand the information that I have provided to the dental office can be disclosed to other health care professionals, under whom I am in care of. I had opportunity to ask questions regarding my medical / dental history. I take responsibility to make payments for myself and my dependents for all the dental treatment provided.

Signature: _____ Dentist: _____

Date: _____