Dangstorp Dental

EMERALD PARK • LAKESHORE • NORTHGATE

Dental Registration and History

Date:_____

1. Patient Information

Patient _____

Mailing Address _____

_____

City Prov. Postal Code

Sex: M____ F____ Age____ Birthdate _____

Does anyone in the immediate family attend this office?____ If so, who?_____

*The office can link family members together.

Hosp #_____ First Canadian Health #_____

Occupation (children not required) _____

Employer Name _____

Employer Phone _____

Spouse's Name _____ Birthdate _____

Employer _____ Occupation _____

2. Phone Numbers

Home_____ Work _____ Ext _____

Cell_____ E-mail _____

Spouse's Work _____ Ext. _____

What is the best method to contact you to remind you of your dental appointment? ❑Home ❑Cell ❑Work ❑Email ❑Text

In case of emergency, contact

Name_____ Relationship_____

Daytime phone _____ Other phone _____

3. Dental Insurance

First Insurance - Relationship to Patient_____ Insurance Co. _____

ID# or Certificate #_____ Policy or Group #_____

Second Insurance - Relationship to Patient _____ Insurance Co. _____

ID# or Certificate # _____ Policy or Group #_____

4. Dental History

Reason for today's visit _____

Former Dentist _____ Address: _____

Date of last dental visit _____ Date of last dental X-rays _____

Please continue on reverse side.

Mark an (x) beside if you have had any of the following:

___ Bad breath
___ Bleeding Gums
___ Clicking or popping jaw
___ Food collection between teeth
___ Grinding/clenching of teeth
___ Loose/broken teeth
___ Facial pain
___ Trigeminal neuralgia
___ Limited opening
___ Neck pain
___ Sensitivity when biting
___ Sores or growths in your mouth
___ Periodontal treatment
___ Sensitivity
___ TMJ pain (jaw joint pain)

5. Health History

Physician's Name _____ Date of last visit _____

Have you had a serious illness or operation? ___Yes ___No If yes, describe _____

Have you ever had a blood transfusion? ___Yes ___No If yes, give approximate dates _____

(Women) Are you pregnant? ___Yes ___No Nursing? ___Yes ___No Taking birth control pills?___Yes ___No

Mark an (x) beside if you have/had any of the following:

___ Aids
___ Anemia
___ Arthritis, Rheumatism
___ Artificial Heart Valve
___ Asthma
___ Back Problems
___ Bell's Palsy
___ Blood Disease
___ Calcium Deficiency
___ Cancer
___ Chem. Dependency
___ Chemotherapy
___ Circulatory Problems
___ Cortisone Treatment
___ Cough, Persistent
___ Cough up Blood
___ Diabetes
___ Epilepsy
___ Fainting
___ Glaucoma
___ Headaches
___ Heart Murmur
___ Heart Problems
describe: _____
___ Hemophilia
___ Hepatitis
___ High Blood Pressure
___ HIV Positive
___ Jaw Pain
___ Joint Replacement
___ Kidney Disease
___ Liver Disease
___ Mitral Valve Prolapse
___ MS
___ Nervous Problems
___ Osteoporosis
___ Pacemaker
___ Psychiatric Treatment
___ Radiation Treatment
___ Respiratory Disease
___ Rheumatic Fever
___ Scarlet Fever
___ Shortness of Breath
___ Skin Rash
___ Stroke
___ Swelling of Feet/ Ankles
___ Thyroid Problems
___ Tobacco Habits
___ Tonsillitis
___ Tuberculosis
___ Ulcer
___ Venereal Disease
___ Vertigo
___ Other

Do you require pre-medication? ___Yes ___No If yes explain why?_____

_____

Medications

List any Medications you are taking:

_____

_____

_____

_____

Allergies

___ Aspirin
___ Barbiturates (sleeping pills)
___ Iodine
___ Latex
___ Other_____
___ Local Anesthetic
___ Penicillin
___ Sulfa

6. Authorization and Release

I have read and answered the above questions to the best of my knowledge. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of patient or parent of minor Date

*** We accept Visa, Mastercard, debit, cash. We expect payment as procedures are provided.**