Date ______________

WELCOME TO OUR OFFICE

REGISTRATION INFORMATION

MEDICAL ALERT	

The information that is requested on this Questionnaire is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly. PLEASE PRINT.

The patient is an: ADULT ☐ CHILD ☐ ADULT UNDER GUARDIANSHIP ☐ Name of Guardian: ______________

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Referred by: ______________

Name: (last) (first) (initial) | (prefers to be called)

Birth Date: M.____ D.____ Y.____

Cell Phone:( )____-______

Address: (street) (Apt.#) (city) (postal code)

Home Phone:( )____-______

E-mail: ______________

Age ___ Sex ___ Marital Status ___ May we call you at work? Yes ☐ No ☐ Employer: ______________

Person responsible for account: ______________ Name of Spouse: ______________

Address: ______________

Do you have insurance? Yes ☐ No ☐ Ins. Co. ______________ Policy/Cert.#(If required by office) ______________

Additional registration information if required by office: ______________

Family Physician: (name) (address) Phone:( )

Are you under the care of a Medical Specialist? Yes ☐ No ☐ Phone:( )

In case of emergency, please contact: Phone:( )

Relationship: ______________

HEALTH HISTORY

Please ✔ YES or NO to each question.

Question	YES	NO
1. Are you being treated for any medical condition at present or within the past year? If yes, please explain: ______________	☐	☐
2. Has there been any change in your general health in the past year? ______________	☐	☐
3. When was your last visit to a Physician? ______________ Last complete physical examination? ______________		
4. Have you recently, or are you presently, taking any PRESCRIPTION or NON-PRESCRIPTION drugs? (including herbal remedies) If yes, please list: ______________	☐	☐
5. Have you ever had any adverse or unusual reaction to any medications or injections? (e.g. penicillin, or other antibiotics, aspirin, codeine, local anaesthetic ("dental freezing")? Please explain: ______________	☐	☐
6. Have you ever been advised against taking any specific type of medication? ______________	☐	☐
7. Do you have any allergies? (e.g. hay fever, food allergies, latex/rubber or metal allergies? ______________	☐	☐
8. Do you have epilepsy or seizures? ______________	☐	☐
9. Have you ever fainted during dental or medical treatment? ______________	☐	☐
10. Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders? Please explain: ______________	☐	☐
11. Are you on any cortisone or steroid therapy, or, are you on a diet pill therapy? ______________	☐	☐
12. Do you have any artificial joints? (hip, knee) ______________	☐	☐
13. Have you ever been advised to take antibiotics before dental treatment? ______________	☐	☐
14. Do you have, or have you ever had, any heart or blood pressure problems? (heart attack or stroke) Please explain: ______________	☐	☐
15. Do you have a heart murmur, valve dysfunction (mitral valve prolapse or artificial heart valve) or have you ever had Rheumatic Fever? ______________	☐	☐
16. Do you have or have you ever had any chest pain, shortness of breath or any heart palpitation without exertion?	☐	☐

MEDICAL HISTORY continued on reverse side