Member AMERICAN ACADEMY OF COSMETIC DENTISTRY®

CANADIAN DENTAL ASSOCIATION

Tri-City Dental Centre

REGISTRATION

Patient's Name _____ **Male** ☐ **Female** ☐
Last **First** **Middle**
Date of Birth _____ **Social Insurance Number**_____
Day Month Year
How do you want to be addressed_____
Single☐**Married**☐**Others**_____
Residence address _____
City_____ **Country**_____ **Postal Code**_____
Telephone: Home_____ **Business:**_____
Cellphone:_____ **E-mail address:**_____
Patient employed by_____ **How long held**_____
Spouse name_____
Last **First** **Middle**
Spouse employed by_____ **How long held**_____

For Minor Patients;
Father's Name_____
Last **First** **Middle**
Employer_____ **How long held**_____
Mother's Name_____
Last **First** **Middle**
Employer_____ **How Long held**_____

Who is responsible for this account_____
Purpose of visit_____
Other family members in the practice _____
Whom may we thank for this referral _____
Someone to notify in case of emergency_____**Phone#**_____

For office use only

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

Patient's or Guardian's signature:_____**Date:**_____

Dental Insurance Coverage:

1st Coverage
Employee Name:_____
Employee Date of Birth_____
Employer_____
Insurance Provider_____
Policy Number_____
SIN/Certificate#_____

2ND Coverage:
Employee Name_____
Employee Date of Birth_____
Employer_____
Insurance Provider_____
Policy Number_____
Sin/Certificate#_____

Tri-City Dental Centre

MEDICAL HISTORY

Patient's Name: _____

Please note: Check the appropriate answer. If you don't know the correct answer, please write DON'T KNOW on the line after the question.

1. Physician's Name _____
   Address _____
2. Are you under a physician's care? ..... YES ☐ NO ☐
   Since when _____ Why _____
3. Are you taking any medications or substances? ..... YES ☐ NO ☐
   (IF YES, please list medication in the "Comments" box to the right)
4. Are you allergic to any medications or substances? ..... YES ☐ NO ☐
5. Do you have any other allergies? ..... YES ☐ NO ☐
6. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES ☐ NO ☐
7. Are you sensitive to any metals or latex? ..... YES ☐ NO ☐
8. Are you pregnant or suspect you may be? ..... YES ☐ NO ☐
9. Have you ever been treated for or been told you might have heart disease? ..... YES ☐ NO ☐
10. Do you have a pacemaker or an artificial heart valve implant? YES ☐ NO ☐
11. Have you ever had rheumatic fever? ..... YES ☐ NO ☐
12. Are you aware of any heart murmurs? ..... YES ☐ NO ☐
13. Do you have high or low blood pressure? ..... YES ☐ NO ☐
14. Have you ever had a serious illness or major surgery? ..... YES ☐ NO ☐
    Please explain: _____
15. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ..... YES ☐ NO ☐
16. Do you have any blood disorder, such as anemia, leukemia, etc.? YES ☐ NO ☐
17. Have you ever bled excessively after being cut or injured? ..... YES ☐ NO ☐
18. Do you have any stomach problems? ..... YES ☐ NO ☐
19. Do you have any kidney problems? ..... YES ☐ NO ☐
20. Do you have any liver problems? ..... YES ☐ NO ☐
21. Are you diabetic? ..... YES ☐ NO ☐
22. Do you have asthma? ..... YES ☐ NO ☐
23. Do you have epilepsy or seizure disorder? ..... YES ☐ NO ☐
24. Do you have or have you/had a venereal disease? ..... YES ☐ NO ☐
25. Have you tested HIV positive? ..... YES ☐ NO ☐
26. Do you have AIDS? ..... YES ☐ NO ☐
27. Have you had or do you test positive for hepatitis? ..... YES ☐ NO ☐
28. Do you or have you had T.B.? ..... YES ☐ NO ☐
29. Do you smoke, chew, use snuff or other form of tobacco? ..... YES ☐ NO ☐
30. Do you consume alcoholic beverages? ..... YES ☐ NO ☐
31. Do you habitually use controlled substances? ..... YES ☐ NO ☐
32. Have you had psychiatric treatment? ..... YES ☐ NO ☐
33. Do you have any disease, condition, or problem not listed? ..... YES ☐ NO ☐
34. Is there anything else we should know about your health that we have not covered in this form? If yes, please explain: YES ☐ NO ☐

    _____
    _____
35. Would you like to speak to the doctor privately about any problem? ..... YES ☐ NO ☐

ALLERGIES:

OFFICE USE ONLY

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient's/Guardian's signature _____ Date _____

Tri-City DentalCentre

DENTAL HISTORY

1. Purpose of initial visit

_____

_____

2. Are you aware of your problem?

_____

_____

3. How long since your last dental visit?_____
4. What was done at the last time?_____
5. Previous dentist's name_____
   Address_____ Telephone_____
6. When was the last time your teeth were cleaned?_____

CHECK THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ..... YES ☐ NO ☐
8. Have you lost any teeth or have any teeth been removed? YES ☐ NO ☐
   Why?_____
9. Have they been replaced? ..... YES ☐ NO ☐
10. Are you unhappy with the replacement? If yes, please explain: YES ☐ NO ☐

_____

_____

11. Would you like to know about permanent replacements?.. YES ☐ NO ☐
12. Have you ever had any problems or complications with previous dental treatment? If yes, please explain ..... YES ☐ NO ☐

_____

_____

13. Do you clench or grind your teeth? ..... YES ☐ NO ☐
14. Does your jaw click or pop? ..... YES ☐ NO ☐
15. Have you experienced any pain or soreness in the muscles of your face or around your ear area? ..... YES ☐ NO ☐
16. Do you have frequent headaches, neck aches or shoulder aches? ..... YES ☐ NO ☐
17. Does food get caught in your teeth? ..... YES ☐ NO ☐
18. Are any of your teeth sensitive to Hot? ☐ Cold? ☐
    Sweets? ☐ Pressure? ☐
19. Do your gums bleed or hurt? ..... YES ☐ NO ☐
    When?_____
20. Are you unhappy with the appearance of your teeth? ..... YES ☐ NO ☐
21. How do you feel about your teeth in general?

_____

22. Do you feel your breath is offensive at times? ..... YES ☐ NO ☐
23. Have you ever had Gum treatment or surgery? ..... YES ☐ NO ☐
24. Have you ever had any orthodontic work? ..... YES ☐ NO ☐
25. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?

_____

_____

26. Do you have any questions or concerns? ..... YES ☐ NO ☐

OFFICE USE ONLY

Patient's/Guardian's Signature_____**Date**_____