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. Th protection and privacy of your personal information is important to our office and we are committed to collecting, using an 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.___

Bus. Phone: ( ) ___ - ___

Address: (street) (Apt.#) (city) (postal code) Home Phone: ( ) ___ - ___

Cell Phone: ( ) ___ - ___

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

Person responsible for account: _____ Name of Spouse: _____

Do you have insurance? Yes ☐ No ☐ Insurance Co. _____ Policy No. _____ Cert. No. _____

Driver's License No. (If required by office)_____ Social Insurance No. (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: ( )

DENTAL HISTORY

(Please ✔ Yes or No to each Question. If unsure of a question, please consult with the dentist.) YES N

Is there a dental problem you would like treated immediately? Yes ☐ No ☐ Date of last dental cleaning: _____ visit: _____ X-rays _____

1. Have you been seeing a dentist regularly? _____
2. Have you ever had any of the following?
   - Periodontal treatment? (treatment of the gums) _____
   - Orthodontic treatment? (to straighten or realign teeth) _____
   - A bite plate or any other appliance? _____
   - Your bite adjusted or teeth ground? _____
   - Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?) _____

   If you answered "yes" to the last question, who performed the surgery? _____ When was it done? _____

   Are you being followed up by a dental specialist? _____
3. Are there any growths or sore spots in your mouth? _____
4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? _____
5. Have you noticed any loose teeth, or, have any of your teeth shifted? _____
6. Does food catch between your teeth? _____
7. Are any of your teeth sensitive to heat, cold, sweets or pressure? _____
8. Have you been advised to take antibiotics before a dental appointment? _____
9. Do you use dental floss, proxabrush or stimudents? How often? _____
10. How often do you brush your teeth? _____ Do you feel that you have bad breath? _____
11. Have you ever experienced any of the following jaw problems:
    - Popping/clicking in your jaw joints? _____
    - Pain in your jaw joints, around your ear, or side of your face? _____
    - Difficulty in opening or closing? _____
    - Pain when teeth are clenched? _____
    - Pain or difficulty while chewing? _____
12. Do you have any of the following habits?
    - Clenching or grinding your teeth while awake or asleep? _____
    - Biting your cheeks or lips? _____
    - Mouth breathing while awake or asleep? _____
    - Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? _____
13. Do you have any emotional concerns about having dental treatment? _____
14. Are you dissatisfied with the appearance of your teeth? _____

    or, What would you like to see changed? _____
15. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? _____

(Complete both sides before signing) **GENERAL RELEASE**

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____ _____

PATIENT ☐ PARENT ☐ GUARDIAN ☐ **(PRINT NAME OF GUARDIAN)**