Marketplace Dental Centre
47-280 Guelph St.
Georgetown, ON L7G 4B1
905-877-2273
www.georgetowndental.com

PATIENT REGISTRATION AND HEALTH HISTORY

MEDICAL ALERT:

***A warm welcome**, in order to provide you with optimum dental care we require a thorough medical and dental history which is unique to you. Be assured that all information is kept strictly confidential. Please take a moment to answer each question on BOTH sides of this questionnaire.*

I. PERSONAL INFORMATION:

FULL NAME: _____ BIRTHDATE: _____ SOC.INS.# _____
DD MM YY

ADDRESS: _____
STREET CITY POSTAL CODE

TEL. HOME: _____ WORK: _____ CELL: _____ E-MAIL: _____

INSURANCE CARRIER: _____ GROUP # _____ ID# _____ EMPLOYER: _____

BASIC: _____ % CROWN/BRIDGE: _____ % REM. PROS: _____ % ORTHO _____ %

NAME OF SPOUSE: _____ BIRTHDATE: _____

SECONDARY CARRIER: _____ GROUP # _____ ID# _____ EMPLOYER: _____

BASIC: _____ % CROWN/BRIDGE: _____ % REM. PROS: _____ % ORTHO _____ %

Whom may we thank for referring you to our office?: _____

II. MEDICAL HISTORY: (*CONFIDENTIAL*)

PHYSICIAN NAME: _____ PHYSICIAN PHONE: _____

		YES	NO
1.	Are you in good health?	☐	☐
2.	Do you smoke?	☐	☐
3.	Have you ever had a serious illness, operation, or hospitalization?	☐	☐
4.	Are you now under the care of a physician for any ongoing treatment or therapy?	☐	☐
5.	My last physical examination was on: _____		
6.	Are you now taking any medicine, drugs, or pills? If yes, please list: _____	☐	☐
7.	Do you have <u>any</u> allergies? If yes, to what? _____	☐	☐
8.	Do you have or have you had any of the following diseases or problems? (Please circle): Any Heart Disease, Artificial Heart Valve, High Blood Pressure, Asthma, Tuberculosis, Any Lung Disease, Hives or Skin Rash, Any Kidney trouble, Hepatitis, Jaundice, Any Liver Disease, Ulcers, Any Arthritis, Rheumatic Fever, Cancer, HIV, Drug Addiction, Hemophilia, Mental or Nervous Disorder, Epilepsy.		
9.	Do you, or has any member of your family had diabetes?	☐	☐
10.	Do you have any blood disorders or do you bleed excessively?	☐	☐
11.	Have you ever had injury, surgery, or x-ray therapy to face or jaws?	☐	☐
12.	Do you have a tendency to faint?	☐	☐
13.	Do you have frequent severe headaches?	☐	☐
14.	Are you on a special diet?	☐	☐
15.	Do you have a prosthetic implant? (i.e. hip?)	☐	☐
16.	WOMEN ONLY - Are you pregnant? (Which month: _____)	☐	☐
17.	Do you have any disease, condition, or problem not listed above that you think the Dentist should know about? If yes, please explain: _____	☐	☐

Date _____ **Patient's Signature** _____

NOTES: _____

PLEASE TURN OVER

III. DENTAL HISTORY:

A. What concerns you most about your dental health? _____

_____

		YES	NO
B.	Do you see a dentist on a routine basis?	☐	☐
	i - Date of last dental visit? _____		
	ii - Date of last dental cleaning? _____		
	iii - Date of last full mouth series of X-rays? _____		
C.	Are you having pain at this time?	☐	☐
D.	Have you ever had:		
	i - Orthodontic treatment (Braces)?	☐	☐
	ii - Oral Surgery?	☐	☐
	iii - Periodontal treatment (Gum Surgery)?	☐	☐
	iv - Worn a bite guard or other appliance?	☐	☐
E.	Have you noticed any loosening of your teeth?	☐	☐
F.	Does food tend to become caught between your teeth?	☐	☐
G.	Do you suffer from pain and/or swelling of your gums?	☐	☐
H.	Do your gums often bleed when you brush your teeth?	☐	☐
I.	Problems of the jaw. Have you experienced:		
	i - Clicking of the jaw?	☐	☐
	ii - Pain (joint, ear, side of face)?	☐	☐
	iii - Difficulty in opening or closing?	☐	☐
	iv - Difficulty in chewing?	☐	☐
J.	Habits. Do you:		
	i - Clench or grind your teeth while awake or asleep?	☐	☐
	ii - Bite your lips or cheeks regularly?	☐	☐
	iii - Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)	☐	☐
	iv - Mouth breathe while awake or asleep?	☐	☐
K.	Do you feel nervous about having dental treatment?	☐	☐
L.	Have you ever had an upsetting experience in a dental office?	☐	☐
M.	Is it important to keep your teeth?	☐	☐
N.	Are you dissatisfied with the appearance of your teeth?	☐	☐
	If you could, what features of your smile would you like to change? _____		
	_____		
O.	Is there anything else about having dental treatment that bothers you?	☐	☐
	Please explain: _____		
	_____		

P. Insurance companies now only allow for 'functionally acceptable work', whereas, in the past their coverage was for 'quality work'. It is our desire to provide our patients with the highest quality work within their financial capabilities and desires. What Is Important to You? (check one)

- ☐ The highest quality dentistry available
- ☐ The most economical treatment plan
- ☐ Dentistry limited to insurance coverage
- ☐ A combination of the above, please explain: _____

_____

General Consent Statement: I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge, and have not knowingly ommited any information. I authorize the dentist to perform necessary diagnostic procedures and treatments to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

_____ _____

Signature - Patient / Parent or Guardian **Date**