

Images Dental Centre

Patient Registration Form (please print)

The following information is necessary in order that the dentist may thoroughly diagnose any condition and give you personal attention. Please fill out the form **completely**. This information is confidential.

Name: _____ Miss Mr. Mrs. Ms. Dr.

Phone No. _____ Cell Ph _____ Work Ph _____

Home Address _____

Postal Code _____ Marital Status _____ Date of Birth _____

Employer _____ Occupation _____

Family Physician _____ Phone No. _____

Emergency Contact _____ Phone No. _____

Do you have Dental Insurance? Yes No

1ST INSURER:

INS CO. _____

Subscriber _____

D.O.B. _____

Employer _____

GRP/Cert # _____ Contract/ I.D.# _____

2ND INSURER:

INS CO. _____

Subscriber _____

D.O.B. _____

Employer _____

GRP/Cert# _____ Contract/I.D.# _____

How did you first hear about our dental office? (Please check appropriate box)

friend office sign yellowpages internet family member other

Who may we thank for referring you? _____

MEDICAL HISTORY

1. How is your health now? _____

2. Are you presently under medical treatment? YES NO Reason _____

3. Are you presently taking any medications or tablets? YES NO If so, please list the medications you are currently taking. _____

4. Have you ever had an unusual reaction to any dental drugs or medicine? (i.e. freezing, nitrous oxide, other.) To what? _____

5. When was your last Dental Visit? _____

6. Do you suffer from any allergies (**LATEX**, food, drug, other) to What?

7. Have you ever experienced prolonged bleeding after a dental extraction or any other abnormal bleeding? _____

8. WOMEN ONLY: Are you pregnant? _____ Due Date _____

9. Have you ever had nitrous oxide or IV sedation before? YES NO

PLEASE TURN OVER PAGE TO CONTINUE

10. Have you ever had any major operations or illnesses? YES NO Specify _____

11. Have you ever been treated for any of the following:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> HIV | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A B C D | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Contagious Disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> TB/Lung Disease | <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Blood Disorders |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> TMJ Pains | <input type="checkbox"/> Heart murmur or mitral valve prolapse | | |

12. Do you smoke? Yes No

13. Do you snore? Yes No I don't know

14. Do you gasp or stop breathing in your sleep? Yes No I don't know

15. Have you ever had any unpleasant dental experience? Explain _____

16. Are you happy with your smile? YES NO

17. What is your present Dental problem? _____

Permit for Procedures

This is to certify that I, undersigned, consent to the performing of the dental procedures agreed, to by me, to be necessary or advisable, including the use of local anesthetic as indicated and I will assume Payment is expected as services are rendered, unless prior financial arrangements have been made. All past due balances are subject to 2.5% interest charged monthly.

Patient's (parent's) Signature: _____ Date: _____

Email Address: _____

What is the BEST way to confirm your appointment with us:

Home Work Cell Email Text Msging (MTS Rogers Telus)

