UPPER VILLAGE
DENTAL CARE

PATIENT REGISTRATION

Prefix: ○ Dr. ○ Mr. ○ Mrs. ○ Ms. ○ Miss

Name: _____

Prefers to be called: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____

Business Phone: _____ Ext.: _____

Cell Phone: _____

E-Mail Address: _____

Date of Birth: _____ Age: _____ Sex: Please Select

Marital Status: Please Select Name of Spouse: _____

Are other family members patients with us? ○ Yes ○ No Name: _____

Whom may we thank for referring you? _____

Family Physician: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Emergency Contact: _____ Phone: _____

PRIMARY DENTAL INSURANCE

Subscriber's Name _____ D.O.B. _____

Emp./Grp. policy holder _____

Ins. Co. _____ Tel. _____

Grp./Ind. policy No. _____ Cert. No. _____

I.D./S.I.N. _____

SECONDARY DENTAL INSURANCE

Subscriber's Name _____ D.O.B. _____

Emp./Grp. policy holder _____

Ins. Co. _____ Tel. _____

Grp./Ind. policy No. _____ Cert. No. _____

I.D./S.I.N. _____

UPPER VILLAGE
DENTAL CARE

MEDICAL HISTORY SECTION

1. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

A.I.D.S.	○ Yes ○ No	Frequent headaches	○ Yes ○ No	Liver disease	○ Yes ○ No
Alcohol dependency	○ Yes ○ No	Frequent throat infections	○ Yes ○ No	Low blood pressure	○ Yes ○ No
Anemia	○ Yes ○ No	Glandular disorders	○ Yes ○ No	Lung disease	○ Yes ○ No
Angina pectoris	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lupus	○ Yes ○ No
Arthritis/rheumatism	○ Yes ○ No	Hay Fever	○ Yes ○ No	Malignant Hyperthermia	○ Yes ○ No
Artificial heart valve	○ Yes ○ No	Hearing difficulty	○ Yes ○ No	Medical implant	○ Yes ○ No
Artificial joints (hip, knee)	○ Yes ○ No	Heart attack	○ Yes ○ No	Mental/nervous disorder	○ Yes ○ No
Asthma	○ Yes ○ No	Heart disease	○ Yes ○ No	Metal allergies	○ Yes ○ No
Bleed or bruise easily	○ Yes ○ No	Heart murmur	○ Yes ○ No	Mitral valve prolapse	○ Yes ○ No
Blood disorders	○ Yes ○ No	Head/neck injuries	○ Yes ○ No	Organ transplant	○ Yes ○ No
Bronchitis	○ Yes ○ No	Heart pacemaker	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Cancer	○ Yes ○ No	Heart rhythm disorder	○ Yes ○ No	Psychiatric treatment	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Heart surgery	○ Yes ○ No	Radiation treatment	○ Yes ○ No
Circulation problems	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Rheumatic fever	○ Yes ○ No
Congenital heart lesions	○ Yes ○ No	Hepatitis B	○ Yes ○ No	Shortness of breath	○ Yes ○ No
Cortisone/steroid	○ Yes ○ No	Hepatitis C	○ Yes ○ No	Sickle cell disease	○ Yes ○ No
Crohn's disease	○ Yes ○ No	Herpes	○ Yes ○ No	Sinus trouble	○ Yes ○ No
Diabetes type I	○ Yes ○ No	High blood pressure	○ Yes ○ No	Skin rashes	○ Yes ○ No
Diabetes type II	○ Yes ○ No	H.I.V.	○ Yes ○ No	Smoking	○ Yes ○ No
Dramatic weight change	○ Yes ○ No	Hodgkins disease	○ Yes ○ No	Stomach problems	○ Yes ○ No
Drug dependency	○ Yes ○ No	Hyperglycaemia	○ Yes ○ No	Stroke	○ Yes ○ No
Emphysema	○ Yes ○ No	Hypoglycaemia	○ Yes ○ No	Swollen ankles/feet/hands	○ Yes ○ No
Epilepsy or seizures	○ Yes ○ No	Inflammatory bowel disease	○ Yes ○ No	Hyperthyroidism	○ Yes ○ No
Eyeglasses/contacts	○ Yes ○ No	Intestinal problems	○ Yes ○ No	Hypothyroidism	○ Yes ○ No
Fainting or dizzy spells	○ Yes ○ No	Jaundice	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Food allergies	○ Yes ○ No	Kidney disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Frequent earaches	○ Yes ○ No	Latex Allergies	○ Yes ○ No	Other _____	

PLEASE ANSWER THE FOLLOWING QUESTIONS:

2. Has the CHILD PATIENT recently had:
   Chicken pox ○ Yes ○ No
   Measles ○ Yes ○ No
   Strep throat ○ Yes ○ No
   Mumps ○ Yes ○ No
   Tonsillitis ○ Yes ○ No

3. **Women only:** Are you pregnant or suspect you may be? ○ Yes ○ No Expected delivery date? _____
   Are you breast feeding? ○ Yes ○ No Birth control pills? ○ Yes ○ No

4. Have you ever been hospitalized? If so, please detail for what: _____

5. When was your last visit to a physician? _____ Last complete physical? _____

6. Are you taking any medication? If so, please detail: _____

7. Are you allergic to any medication? If so, please detail: _____

8. Do you currently have, or had in the past, any disease, condition or problem not listed above? _____

_____

UPPER VILLAGE
DENTAL CARE

DENTAL HISTORY SECTION

1. Is there a dental problem you would like treated immidiately? If so, please detail: _____

_____

2. Date of your last dental visit?_____ Last dental cleaning?_____ Last x-rays?_____

3. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

Bleeding gums	○ Yes	○ No	Emotional concerns for Dental treatment	○ Yes	○ No	Nail biting	○ Yes	○ No
Braces	○ Yes	○ No				Painful gums	○ Yes	○ No
Chewing pain	○ Yes	○ No	Food catching between teeth	○ Yes	○ No	Root canals	○ Yes	○ No
Clenching appliance	○ Yes	○ No	Frequent bad breath	○ Yes	○ No	Sensitive teeth to chewing	○ Yes	○ No
Clenching your teeth	○ Yes	○ No	Frequent biting of cheeks	○ Yes	○ No	Sensitive teeth to cold	○ Yes	○ No
Clicking jaw joint	○ Yes	○ No	Frequent biting of lips	○ Yes	○ No	Sensitive teeth to sweets	○ Yes	○ No
Complication during or after dental treatment	○ Yes	○ No	Grinding your teeth	○ Yes	○ No	Shifted teeth	○ Yes	○ No
			Growths in your mouth	○ Yes	○ No	Sore spots in your mouth	○ Yes	○ No
Dental implants	○ Yes	○ No	Gum surgery	○ Yes	○ No	Swollen gums	○ Yes	○ No
Difficulty opening	○ Yes	○ No	Jaw joint pain	○ Yes	○ No	Wisdom teeth removed	○ Yes	○ No
Difficulty closing	○ Yes	○ No	Jaw surgery	○ Yes	○ No	Other _____		
Difficulty chewing	○ Yes	○ No	Loose teeth	○ Yes	○ No	Other _____		

4. Have you been advised to take antibiotics before a dental appointment? ○ Yes ○ No

5. How often do you brush your teeth? _____

6. How often do you floss your teeth? _____

7. On a scale of 1 to 10 please rank your personal satisfaction with your oral health and smile Please Select

GENERAL RELEASE : TO BE SIGNED AT THE OFFICE

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 service.

X _____ _____

(signature) Patient ☐ Parent ☐ Guardian ☐ (print name of guardian)

Reviewed by Treating Dentist: _____ Date: _____