SELKIRK CROSSING DENTAL CENTRE

Patient Registration

First Name: _____Last Name: _____ Middle Initial:____

Preferred Name: _____

Information

Birth Date (DD/MM/YY): _____ Age: _____

Gender: _____ Family Status (circle one): Married Single Child Other_____

Address: _____

City/Province: _____ Postal Code: _____

Home Ph: _____ Work Ph: _____ Ext: _____

Cell Ph: _____ Email: _____

How did you hear about us: _____Previous Dentist: _____

Emergency Contact: _____Emergency Contact #: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____

Address: _____

City/Province: _____ Postal Code: _____

Home Ph: _____ Work Ph: _____ Ext: _____

Cell Ph: _____ Email: _____

Birth Date (MM/DD/YY): _____

Primary Insurance Information

Name of Insured: _____ Birth Date (DD/MM/YY):_____

Relationship to Insured (circle one): Self Child Spouse Common Law Other

Insurance Company: _____ Employer: _____

Group #: _____ ID #: _____

Secondary Insurance Information

Name of Insured: _____ Birth Date (DD/MM/YY):_____

Relationship to Insured (circle one): Self Child Spouse Common Law Other

Insurance Company: _____ Employer: _____

Group #: _____ ID #: _____

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Medical History

Date of Last Dental Visit: _____ **Reason**: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you have, or medication that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Are you under a physician's care now?	□ Yes	□ No
Have you ever been hospitalized or had a major operation?	□ Yes	□ No
Have you ever had a serious head or neck injury?	□ Yes	□ No
Are you taking medications, pills, or drugs?	□ Yes	□ No
Are you on a special diet?	□ Yes	□ No
Do you use tobacco?	□ Yes	□ No
Do you use controlled substances?	□ Yes	□ No

If "yes" to any of the above, please explain: _____

Women: Are you…

Pregnant/Trying to get pregnant? □ Yes □ No Taking oral contraceptives: □ Yes □ No Nursing: □ Yes □ No

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetic □ Sulpha
□ Other (please explain): _____

Do you have, or have you had any of the following:

AIDS/HIV Positive	□ Yes □ No	Excessive Bleeding	□ Yes □ No	Lung Disease	□ Yes □ No
Alzheimer's Disease	□ Yes □ No	Excessive Thirst	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No
Anaphylaxis	□ Yes □ No	Fainting/Dizziness	□ Yes □ No	Pain in Jaw Joints	□ Yes □ No
Anemia	□ Yes □ No	Frequent Cough	□ Yes □ No	Parathyroid Disease	□ Yes □ No
Angina	□ Yes □ No	Frequent Diarrhea	□ Yes □ No	Psychiatric Care	□ Yes □ No
Arthritis/Gout	□ Yes □ No	Frequent Headaches	□ Yes □ No	Radiation Treatments	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Genital Herpes	□ Yes □ No	Recent Weight Loss	□ Yes □ No
Artificial Joint Replacement	□ Yes □ No	Glaucoma	□ Yes □ No	Renal Disease	□ Yes □ No
Asthma	□ Yes □ No	Hay Fever	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Blood Disease	□ Yes □ No	Heart Attack/Failure	□ Yes □ No	Rheumatism	□ Yes □ No
Blood Transfusion	□ Yes □ No	Heart Murmur	□ Yes □ No	Scarlet Fever	□ Yes □ No
Breathing Problem	□ Yes □ No	Heart Pace Maker	□ Yes □ No	Shingles	□ Yes □ No
Bruise Easily	□ Yes □ No	Heart Trouble/Disease	□ Yes □ No	Sickle Cell Disease	□ Yes □ No
Cancer	□ Yes □ No	Hemophilia	□ Yes □ No	Sinus Trouble	□ Yes □ No
Chemotherapy	□ Yes □ No	Hepatitis A	□ Yes □ No	Spina Bifida	□ Yes □ No
Chest Pains	□ Yes □ No	Hepatitis B or C	□ Yes □ No	Stomach/Intestinal Disease	□ Yes □ No
Cold Sores/Fever Blisters	□ Yes □ No	Herpes	□ Yes □ No	Stroke	□ Yes □ No
Congenital Heart Disorder	□ Yes □ No	High Blood Pressure	□ Yes □ No	Swelling of Limbs	□ Yes □ No
Convulsions	□ Yes □ No	Hives or Rash	□ Yes □ No	Thyroid Disease	□ Yes □ No
Cortisone Medicine	□ Yes □ No	Hypoglycemia	□ Yes □ No	Tonsillitis	□ Yes □ No
Diabetes	□ Yes □ No	Irregular Heartbeat	□ Yes □ No	Tuberculosis	□ Yes □ No
Drug Addiction	□ Yes □ No	Kidney Problems	□ Yes □ No	Tumors or Growths	□ Yes □ No
Easily Winded	□ Yes □ No	Leukemia	□ Yes □ No	Ulcers	□ Yes □ No
Emphysema	□ Yes □ No	Liver Disease	□ Yes □ No	Venereal Disease	□ Yes □ No
Epilepsy/Seizures	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Yellow Jaundice	□ Yes □ No

Have you ever had any serious illness not listed above? □ Yes □ No
Comments: _____

Privacy Consent

Personal information is kept private by our dentists. Information would be released for due diligence purposes. Payment is required at the time services are rendered. We are happy to provide you with an estimate. You may pay your account with Visa, Mastercard, debit, or cash. I authorize the dental personnel to perform services for prevention and treatment of dental disease using the procedures and medications required and assume responsibility for the fees associated with those procedures.

Signature of patient or parent/guardian: _____ Date: _____