GLENCAIRN DENTAL
FAMILY & COSMETIC DENTISTRY

Registration Form

Patient Information (PLEASE PRINT CLEARLY):

Date: _____

Email Address: _____

Last Name: _____ First Name: _____ Middle Initial:_____

Sex: □ Male □ Female Date of Birth (dd/mm/yy)_____ Age: _____

Marital Status: _____ Identification checked (Driver's License/Health Card): □ Yes □ No

Address: _____ Apt#: _____ City: _____

Province: _____ Postal Code: _____ How long at this address: _____

Home #: (____) ____ - _____ Work #: (____) ____ - ____ ext: ____ Cell #: (____) ____ - _____

Occupation: _____ Employer: _____ # of years employed: _____

Relationship to Patient (dependent under 18 yrs) Full Name: _____

Reason for this visit_____

How did you hear about us (Friend, Radio, Television…)? _____

Emergency Contact Information - RELATIVE NOT LIVING WITH YOU:

Full Name: _____ Relationship: _____

Home #: (____) ____ - _____ Work #: (____) ____ - ____ ext: _____ Cell #: (____) ____ - _____

Dental Insurance(s) Information:

PRIMARY	**SECONDARY**
Member's Full Name: _____	Member's Full Name: _____
Date of Birth (dd/mm/yy):_____	Date of Birth (dd/mm/yy): _____
Insurance Company: _____	Insurance Company:_____
Employer: _____	Employer:_____
Policy/Group #: _____	Policy/Group#:_____
Certificate/ID #: _____	Certificate/ID#:_____

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Dental History

How long since your have seen a dentist? _____

Last complete dental exam, Date: _____

Last full mouth x-rays, (16 small films or panoramic) Date: _____

Are you having problems now? _____

If yes explain: _____

Is your present dental health poor? ☐Yes ☐No

Do you wear dentures? (Partial or Full) ☐Yes ☐No

Are you unhappy with your dentures? ☐Yes ☐No

Would you like to know more about permanent replacement? ☐Yes ☐No

Are you apprehensive about dental treatment ☐Yes ☐No

Have you had any periodontal (gum) treatment ☐Yes ☐No

Do your gums bleed, or feel tender or irritated? ☐Yes ☐No

Are your teeth sensitive to hot, cold, sweets, pressure? ☐Yes ☐No

Are you unhappy with the appearance of your teeth? ☐Yes ☐No

Are you aware of grinding or clenching of your teeth? ☐Yes ☐No

Do you have headaches, earaches, or neck pains? ☐Yes ☐No

Have you worn braces on your teeth (orthodontics)? ☐Yes ☐No

Do you have discoloured teeth that bother you? ☐Yes ☐No

Would you like your smile to look better or different? ☐Yes ☐No

Do you regularly use dental floss? ☐Yes ☐No

How do you feel about your teeth? _____

Please rank the following in the order in which they would keep you from having dental treatments:

Fear of pain # _____ Lack of concern # _____

Cost of treatment # _____ Missing work # _____

Previous Dentist Name: _____

Telephone Number: _____

City: _____ Province: _____

Family Physician: _____

Telephone Number: _____

City: _____ Province: _____

It is important that I know your medical and dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Medical History

Do you have any current health problems? ☐Yes ☐No

Are you under a physician's care now? ☐Yes ☐No

If yes explain: _____

What medications are you currently taking? _____

Have you ever taken Fen-Phen/Redux? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No

Do you use cigars/cigarettes, pipe or chew tobacco? ☐Yes ☐No

Please check ✓ Yes or No for the following which you have had or presently have:

AIDS/HIV Pos.	☐Yes ☐No	Herpes	☐Yes ☐No
Anaphylaxis	☐Yes ☐No	Hepatitis	☐Yes ☐No
Anemia	☐Yes ☐No	High blood pressure	☐Yes ☐No
Arthritis	☐Yes ☐No	Jaw Pain	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Kidney disease or malfunction	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Liver disease	☐Yes ☐No
Asthma	☐Yes ☐No	Material allergies (latex, wool, metal, chemicals)	☐Yes ☐No
Back Problems	☐Yes ☐No	Mitral valve prolapse	☐Yes ☐No
Blood Disease	☐Yes ☐No	Nervous problem	☐Yes ☐No
Cancer	☐Yes ☐No	Pacemaker/heart surgery	☐Yes ☐No
Chemical dependency	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Rapid weight gain/loss	☐Yes ☐No
Circulatory problems	☐Yes ☐No	Radiation treatment	☐Yes ☐No
Cortisone Treatment	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Cough (Persistent)	☐Yes ☐No	Rheumatic/scarlet fever	☐Yes ☐No
Cough up blood	☐Yes ☐No	Shingles	☐Yes ☐No
Diabetes	☐Yes ☐No	Shortness of breath	☐Yes ☐No
Epilepsy	☐Yes ☐No	Skin rash	☐Yes ☐No
Fainting	☐Yes ☐No	Spina Bifida	☐Yes ☐No
Food Allergies	☐Yes ☐No	Stroke	☐Yes ☐No
Glaucoma	☐Yes ☐No	Surgical implant	☐Yes ☐No
Headaches	☐Yes ☐No	Swelling of feet or ankles	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Tobacco habit	☐Yes ☐No
Heart Problems	☐Yes ☐No	Tonsillitis	☐Yes ☐No
If yes please describe _____		Ulcer/Colitis	☐Yes ☐No
		Venereal disease	☐Yes ☐No
		Hemophilia (Abnormal Bleeding)	☐Yes ☐No

Are you allergic to or have you reacted adversely to any of the following medication: ☐Yes ☐No known allergies

☐ Aspirin ☐ Local Anaesthetic ☐ Erythromycin ☐ Latex (balloons, gloves etc.)
☐ Nitrous Oxide ☐ Codeine ☐ Penicillin

Are you aware of being allergic to any other medications or substances?
☐Yes ☐No
If yes, list: _____

Is there any other medical or dental information that you feel I should know about?
☐Yes ☐No
If yes, list: _____

Responsibility & Consent Form

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 help me understand the nature of the enquiries listed in this form and was able to answer them thoroughly and truthfully. **Should there be any changes in my health status in the future, I will advise Sun Dental Care.** I authorize the dentist to perform diagnostic procedures as required to determine the necessary treatment and, I consent to the release of medical- dental information from previous/present health/dental care providers to Sun Dental Care as deemed necessary. **I understand that I am fully responsible for the payments pertaining to all dental services provided to me and my dependants and, any fees due are payable at the time services are rendered.**

Patient Signature (Parent of Dependent): _____

Office Signature: _____