NORTHSIDE DENTAL OFFICE
DENTAL REGISTRATION FORM - ADULT

1 PATIENT INFORMATION

Patient Name: _____ Date: _____

Address: _____ (#) _____ (Street Name) _____ (City) _____ (Prov.) _____ (Postal Code)

Phone Home: _____ Cell: _____ Work: _____

Health Card # _____ _____ (Series) Sex: ☐ M ☐ F Age _____ Birthdate _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Birthdate: _____

Who may we thank for referring you? _____

2 DENTAL INSURANCE

Policy Holder Name: _____

Insurance Co.: _____ Group # _____

Certificate # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Secondary
Subscriber's Name: _____

Insurance Co.: _____ Group # _____

Certificate # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage

with _____ and assign directly to Dr. _____ all insurance benefits, if any,

otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ (Responsible Party Signature) _____ (Date)

3 DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ Address _____

Date of last dental visit _____ Date of last dental X-rays _____

Place a mark on "YES" or "NO" in the box to indicate if you have had any of the following:

Bleeding gums ☐ Yes ☐ No

Cigarette, pipe, or cigar smoking ☐ Yes ☐ No

Dry mouth ☐ Yes ☐ No

How often do you floss? _____

How often do you brush? _____

Have you ever been given local anaesthetic (freezing)? ☐ Yes ☐ No Any complication? _____

Have you ever been given general anaesthetic? ☐ Yes ☐ No Any complication? _____

4 HEALTH HISTORY

Family Physician's Name: _____ Date of last visit: _____

Are you presently under the care of a physician for any ongoing illness? Yes ☐ No ☐ List _____

Have you ever been hospitalized or had surgery performed? Yes ☐ No ☐ List _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Women:	☐ Yes	☐ No	
Anemia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Are you pregnant?	☐ Yes	☐ No	
Arthritis, Rheumatism	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Due date _____			
Artificial Heart Valves	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Are you nursing?	☐ Yes	☐ No	
Artificial Joints	☐ Yes	☐ No	Type _____						
Asthma	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	
Back Problems	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Recreational Drug Use	☐ Yes	☐ No	
			HIV Positive	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No	
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No	
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	
Congenital Heart Disease	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No	
COPD	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	
Cortisone or Steroid Treatments	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No	
Emphysema	☐ Yes	☐ No				Ulcer	☐ Yes	☐ No	
Diabetic - Type _____	☐ Yes	☐ No				Venereal Disease	☐ Yes	☐ No	
						Weight Loss, unexplained	☐ Yes	☐ No	

Is there any other medical information that we should be aware of ? ☐ Yes ☐ No

_____

MEDICATIONS

List medications and dosages you are currently taking:

_____

_____

_____

_____

_____

_____

Pharmacy Name: _____

ALLERGIES

☐ No Known Allergies

☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Latex
☐ Local Anesthetic
☐ Food
☐ Penicillin
☐ Sulpha
☐ Other _____

5 CONSENT

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable including the use of local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's Signature: _____ Date: _____