REGISTRATION INFO

First name:
Last name:
Address:
Home Phone:
Cell Phone:
date of birth:
email:
how did you hear about us:

MEDICAL INFO

Family physician:
Medical specialist (if presently under care):
Are you being treated for any medical condition at present or within the past 2 years? Yes
If yes please explain:
When was your last physical examination?
Please list all prescription or non - prescription medications you are presently taking including herbal remedies:
Do you have any allergies? Yes
Do you bruise easily or bleed abnormally? Yes
Do you experience shortness of breath? Yes
Have you had any weight change recently? Yes
Have you ever had heart disease or murmur? Yes
Have you ever had radiation treatment or chemotherapy? Yes
Women only : are you pregnant? Yes
Do you smoke or use any other forms of tobacco? Yes
Do you have or ever had any of the following? Yes

- ☐ Heart trouble
- ☐ high blood pressure
- ☐ rheumatic fever
- ☐ kidney trouble
- ☐ liver trouble
- ☐ diabetes
- ☐ epilepsy
- ☐ thyroid trouble
- ☐ tuberculosis
- ☐ asthma
- ☐ blood disorders
- ☐ HIV virus
- ☐ hepatitis
- ☐ osteoporosis

DENTAL HISTORY

Is there a dental problem you would like to treat immediately? Yes

Date of your last dental visit?

Have you been seeing a dentist regularly? Yes

Have you ever been advised to take antibiotics before a dental appointment? Yes

Do you have any emotional concerns about having dental treatment? Yes

On a scale 1 – 10 (one being the lowest) how would you rate your smile?

Is there anything you would like to change about your smile?

What are your expectations of us as your dental office?

FINANCIAL INFORMATION

If you have any dental insurance please bring all the information with you including the policy number and certificate number as well as the booklet if you have one.

Primary dental insurance name:

secondary dental insurance name:

EMAIL