WELCOME TO 4TH AVENUE DENTAL CENTRE

The following is strictly confidential and will only be used according to The Personal Information Consent. Provided phone numbers and email address will only be used to communicate between the reception staff at 4th Avenue Dental Centre and you

PATIENT REGISTRATION

Name _____

Last First MI Preferred

Date of Birth (DD/MM/YYYY) _____ Gender: ☐ M ☐ F

Home Phone _____ Work Phone _____

Wireless Phone _____ Email Address _____

Address _____

City _____ Prov _____ Postal Code _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____

Physician Name / Phone _____

Employer's Name: _____

Were you referred to this office? ☐ Y ☐ N If yes, by whom? _____

PLEASE TURN OVER

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Medical History for New Patient

1. Are you in good health now: Y ☐ N ☐
2. List all medications that you are now taking (Prescription, non prescription & recreational): If needed, attach list: _____
3. Are you allergic to or ever had a reaction to any of the following?

Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Latex	☐	☐	Penicillin
☐	☐	Codeine	☐	☐	Local Anesthetic (freezing)	☐	☐	Metals
☐	☐	Ibuprofen	☐	☐	Sulfa drugs	☐	☐	Other

4. Do you have/ever had any of the following conditions?

Y	N		Y	N		Y	N	
☐	☐	Angina	☐	☐	Diabetes	☐	☐	Joint Replacement
☐	☐	Artificial Heart Valve	☐	☐	Drug/Alcohol Addiction	☐	☐	HIV Positive
☐	☐	Asthma	☐	☐	Epilepsy or Seizure	☐	☐	Kidney Disorder
☐	☐	Arthritis	☐	☐	Head/Face/Neck Injury	☐	☐	Malignant Hyperthermia
☐	☐	Blood Disorder	☐	☐	Heart Attack/ Stroke	☐	☐	Mental Disorder
☐	☐	Bone Diseases	☐	☐	Heart Defect	☐	☐	Sinus Trouble
☐	☐	Cancer or Tumor	☐	☐	Hepatitis or Liver Disease	☐	☐	Stomach Ulcer
☐	☐	Cardiac Transplant	☐	☐	High/Low Blood Pressure	☐	☐	Tuberculosis
☐	☐	Cortisone/Steroid Therapy	☐	☐	History of Endocarditis	☐	☐	Others

5. Women: Are you pregnant? Y ☐ N ☐ Due date:_____
6. Is there anything else that we should know about your health? Y ☐ N ☐

Dental History

7. What is the main purpose of your visit today? _____
8. When was your last dental exam? _____
9. Do you have any sore, aching or sensitive teeth? Y ☐ N ☐
10. Do you have gums bleed when you brush your teeth? Y ☐ N ☐
11. Have you ever had any of the following: (Please check)
    - ☐ Orthodontics ☐ Motor Vehicle Accident ☐ Wisdom teeth extracted
    - ☐ Jaw Surgery ☐ Splint/Nightguard
12. Are you aware of any clenching or grinding your teeth? Y ☐ N ☐
13. Do you have any clicking, popping or pain in your jaw joint? Y ☐ N ☐
14. Do you have any missing teeth that you feel should be replaced? Y ☐ N ☐
15. Rate in order what is most important to you: ____ Quality ____ Time _____ Money
16. How do you rate yourself as a dental patient? ☐ Calm ☐ Slightly nervous ☐ Very nervous

I hereby certify that the above information is true. I consent to the dental procedures agreed to be necessary or advisable, including the use of local anesthetics or other medications as indicated, and I will assume responsibility for fees associated with those procedures

Date: _____ Patient's (Guardian's) Signature _____