PATIENT REGISTRATION AND HEALTH HISTORY ***MEDICAL ALERT*_____**

Mr./Mrs./Ms/Miss/Dr Last Name:_____First:_____ Birth date: M_____D_____Y_____(M) or (F)

Address: _____ Postal Code: _____

Home#_____ Cell#_____Work#_____Email_____

Identification: Drivers licence number:_____ (Or) Care card number:_____

Employer:_____Occupation: _____Emergency Contact:_____

Please circle best method/number for us to contact you **HOME / WORK / CELL / EMAIL / SMS**

How did you hear about our office? _____

CIRCLE ALL OF THE FOLLOWING CONDITIONS THAT YOU HAVE, OR HAVE HAD IN THE PAST

AIDS	Anemia	Allergies/Hives	Angina pectoris	Arthritis/Rheumatism
Artificial heart valve	Artificial joints (hip,knee)	Asthma	Blood disorders (specify): _____	
Bronchitis	Bruise easily	Cancer(specify): _____	Circulation problems	Cold sores
Congenital heart lesion	Cortisone/Steroid meds (specify): _____		Diabetes	Drug addiction
Emphysema	Epilepsy/Seizures	Fainting/dizziness	Glandular disorders	Glaucoma
Hay fever	Head/neck injury	Heart disease	Heart attack	Heart murmur
Heart failure	Pacemaker/Arrhythmia	Heart surgery (specify):_____		Hemophilia
Hepatitis A	Hepatitis B	Hepatitis C	Herpes	High blood pressure
Low blood pressure	HIV positive	Hyperglycemia	Hypoglycemia	Jaundice
Kidney disease	Liver disease	Lung disease	Lupus	Malignant hyperthermia
Mental/Nervous disorder	Mitral valve prolapse	Organ transplant	Psychiatric treatment	Radiation treatment
Chemotherapy	Rheumatic/Scarlet fever	Sickle cell disease	Sinus trouble	Stomach disease/Ulcers
Intestinal problems	Stroke	Thyroid disease	Tuberculosis	Venereal disease
Multiple Sclerosis				

Other (specify): _____

ARE YOU ALLERGIC OR HAVE YOU REACTED TO ANY OF THE FOLLOWING MEDICATIONS? PLEASE CIRCLE

Acetaminophen (Tylenol)	Amoxicillin	Aspirin	Codeine	Clindamycin
Demerol	Diazepam (Valium)	Erythromycin	Local Anesthetic	Lorazepam (Ativan)
Metronidazole	Nitrous Oxide	Novocaine	Penicillin	Percocet
Sleeping Pills	Sulpha Drugs	Triazolam (Halcion)		

Are you aware of being allergic to any other medications or substances? (Specify): _____

PLEASE LIST ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

When was your last medical examination with a physician?_____

What is your physician's name?_____ **Phone:** _____

Do you smoke? YES / NO If yes, how long have you smoked, and how many per day?_____

For WOMEN only: Are you pregnant? YES / NO If yes, what is the expected due date?_____

DENTAL HISTORY

Have you had regular dental exams in the past? YES / NO When was your last dental visit? _____

Have you ever had abnormal bleeding or other problems associated with dental extractions or procedures? YES / NO

Have you ever had local anesthetic or dental "freezing"? YES / NO

Are you experiencing dental pain? YES / NO Are you happy with the appearance of your teeth? YES / NO

Do you clench or grind your teeth? YES/ NO Are you apprehensive or nervous about dental treatment? YES / NO

Is there anything you wish to speak privately with the doctor about? YES / NO

CONSENT TO TREATMENT

1. I certify that the above information is correct to the best of my knowledge.
2. I authorize the doctor upon consultation and direct consent from the patient/guardian to perform diagnostic procedures.
3. I understand I am responsible for any fees not covered by my dental insurance.

_____ _____ Patient ( ) Parent ( ) Guardian( )

Date: Signature: please check the applicable category