New Patient Registration

Patient Information:

Name: ________________________ **Sex/Pronoun**: ______________ **D.O.B:**_______________

Address:_______________________ **City**:_____________ **Postal Code**:____________ **Province**:___

Home:(____)___________________ **Cell**: (___)__________________

Email:__________________________________ **Referred by**:____________________

Responsible Party:

Name:_______________________ **Contact#:**(___)_______________**Relationship:**________________

Emergency Contact:

Name:_______________________ **Contact #:**(___)_______________**Relationship:**________________

Insurance Information

Primary	**Secondary**
Policy Holder: ____________________	**Policy Holder:** ____________________
DOB: _______________	DOB: _______________
Employer: __________________________	Employer: __________________________
Ins. Company: _______________________	Ins. Company: _______________________
Group/Plan#: _______________________	Group/Plan#: _______________________
ID/Cert#____________________________	ID/Cert#____________________________

Medical History

1. Are you under the care of a physician?
   ____
2. Are you taking any drugs are medicine?
   ____
3. When was your last medical exam?
   ____
4. Do you have any allergies?
   ____
5. Are you taking any Blood thinning medication?
   ____
6. Have you ever had a surgery?
   ____

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7. Please Circle if you Have or have Had any of the following Medical Conditions:

Asthma	Anemia	**Angina**	**Breast Lump**
Cancer	**Covid**	Ear/Eye Disorder	**Diabetes** ___
High BP	Low BP	**Hay Fever**	Heart Attack
Heart Disease	**Hepatitis B**	Headaches	**Seizure/Epilepsy**
Thyroid	Ulcer	Osteoporosis	Arhritis

Please specify: ____

8. Are you pregnant? ____ Due date: ___________
9. Are you Nursing? ______
10. Are you taking any Birth control? ______

<u>Dental History</u>

1. Last Dental Visit: _________ Last Cleaning: ___________ X-Rays: _____________
2. What was the reason you left? ____
3. How often do you see your dentist? _______________________________________
4. Are you teeth sensitive to (**<u>Circle</u>**): **Cold Heat Sweets Other** ________________
5. Do your gums **bleed**? Or they **swollen**, or **tender**? (**<u>Circle</u>**)
6. Does food get struck between your teeth? _______
7. Are you aware of any loose teeth? _______
8. Do you grind or clench your teeth? _______
9. Do you have dry mouth? ______
10. When you open your jaw widely does it **crack**, **pop**, or **grate** (**<u>Circle</u>**)
11. Are you nervous about going to the dentist? _________
12. How can we help you achieve your dental goal?______________________________

<u>Financial Terms</u>

Please note that the patient/guardian are responsible for any services not covered by <u>the insurance</u>. In the event your insurance does not give us an immediate response we will collect **20% for Basic and 50% for Major** services. This alternative may result in a small balance or credit on your account once the insurance payment has been received.

To the best of my knowledge, all the proceeding answers are true and correct. If I ever have any changes to my health or if my medicine changes, I will inform the doctor at my next appointment without fail.

<u>Please note that we require a 24hr notice to any change or cancelation to avoid the $100 cancellation fee.</u>

________________ ____

(Date) **(Patient, Parent/Guardian's Signature)**