NOVO DENTAL CENTRE

Patient Registration

Please fill out the following information for yourself or your child:

Date: _____ Gender: ☐ M ☐ F

Name: Mr./Mrs./Ms./Miss/Dr._____ Preferred Name: _____

Parent/Guardian's Name: _____

Birthdate: _____ Email Address: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Please check preferred contact number: ☐ Home Phone Number: _____

☐ Work Number: _____ ☐ Cell Number: _____

Spouse: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

How did you hear about us? _____

Did someone refer you, who? _____

Emergency Contact:

Contact name: _____ Relationship: _____

Phone number: _____ Address: _____

Dental Benefits:

Primary Benefits: _____ Employer: _____

Policy Holder: _____ Card Holder's Birthdate: _____

Group Number: _____ ID/ Cert. Number: _____ Div. Number: _____

Secondary Benefits: _____ Employer: _____

Policy Holder: _____ Card Holder's Birthdate: _____

Group Number: _____ ID/ Cert. Number: _____ Div. Number: _____

NOVO DENTAL CENTRE

Medical History

Name: _____ Preferred Name:_____

Name of Physician: _____ Date of last physical exam:_____

What is your estimate of your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever had the following?	(Select Yes or No)	
1. Hospitalized for illness or injury	☐	☐
2. Allergic reaction to:		
Aspirin	☐	☐
Ibuprofen / Acetaminophen	☐	☐
Penicillin	☐	☐
Erythromycin	☐	☐
Codeine	☐	☐
Local Anesthetic (dental freezing)	☐	☐
Fluoride	☐	☐
Metals (gold, stainless steel)	☐	☐
Latex	☐	☐
Other: _____	☐	☐
3. Heart Attack or Heart Related Problems	☐	☐
4. Pacemaker or Stent When was it placed: _____	☐	☐
5. Heart Murmur	☐	☐
6. Angina	☐	☐
7. Rheumatic Fever	☐	☐
8. Heart Disease	☐	☐
9. Scarlet Fever	☐	☐
10. High Blood Pressure	☐	☐
11. Low Blood Pressure	☐	☐
12. Stroke	☐	☐
13. History of Infective Endocarditis	☐	☐
14. Artificial Prosthesis (Heart valve / Joint replaced)	☐	☐
15. Anemia or other blood disorder	☐	☐
16. Bruise easily or bleed abnormally	☐	☐
17. Fainting / Dizzy Spells	☐	☐
18. Emphysema	☐	☐
19. Lung Disease	☐	☐
20. Tuberculosis	☐	☐
21. Shortness of Breath	☐	☐

NOVO DENTAL CENTRE

Medical History Continued

Have you ever had the following?		(Select Yes or No)
22. Asthma	☐	☐
23. Snoring / Breathing Problems	☐	☐
24. Sinus Problems	☐	☐
25. Kidney Disease	☐	☐
26. Liver Disease	☐	☐
27. Jaundice	☐	☐
28. Thyroid or Parathyroid Disease	☐	☐
29. Hormone Deficiency	☐	☐
30. High Cholesterol	☐	☐
31. Diabetes	☐	☐
32. Stomach or Duodenal Ulcer	☐	☐
33. Digestive Disorders (i.e. Gastric Reflux, Crohn's, IBS)	☐	☐
34. Arthritis	☐	☐
35. Osteoporosis Do you take or have you ever taken any medications for this?_____ When did the treatment begin? _____ When did the treatment end? _____	☐	☐
36. Glaucoma	☐	☐
37. Contact Lenses	☐	☐
38. Head or Neck injuries	☐	☐
39. Epilepsy (Seizures)	☐	☐
40. Viral Infection and cold sores	☐	☐
41. Lumps or swelling in the mouth	☐	☐
42. Hives, skin rash or hay fever	☐	☐
43. Venereal Disease	☐	☐
44. Hepatitis (Type ____)	☐	☐
45. HIV/AIDS	☐	☐
46. Tumor or abnormal growth	☐	☐
47. Cancer	☐	☐
48. Radiation therapy	☐	☐
49. Chemotherapy	☐	☐
50. Emotional problems	☐	☐
51. Depression with medication	☐	☐
52. Eating Disorder	☐	☐
53. Alcohol/Drug dependency	☐	☐
54. Psychiatric treatment	☐	☐
55. Bad gag reflex/watery eyes	☐	☐

NOVO DENTAL CENTRE

Medical History Continued

Are You?	(Select Yes or No)	
56. Presently being treated for an illness	☐	☐
57. Aware of any changes in your general health	☐	☐
58. Taking any diet supplements	☐	☐
59. Often exhausted or fatigued	☐	☐
60. Subject to frequent headaches	☐	☐
61. A smoker / chew tobacco	☐	☐
62. Often unhappy or depressed	☐	☐
63. Easily upset or irritated	☐	☐
64. FEMALE- taking birth control pills	☐	☐
65. FEMALE- pregnant	☐	☐
66. FEMALE- breastfeeding	☐	☐
67. MALE- prostate disorders	☐	☐

Have you been advised to take antibiotic pre-medication prior to dental treatment? ☐ Yes ☐ No

Have you been warned against taking any drugs or medication? ☐ Yes ☐ No

Please describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment: _____

_____

Anything else about yourself that the doctor should know about? _____

_____

List any prescription and over-the-counter medications taken within the last two years (including vitamins & supplements):

_____

Do you take a blood thinner? ☐ Yes ☐ No If so, which one:

Do we have permission to speak to your physician regarding your medical history? ☐ Yes ☐ No

Please advise us in the future of any changes in your medical history or in medications you may be taking.

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

NOVO DENTAL CENTRE

Dental History

Please answer the following questions to the best of your ability:

Former Dentist: _____ City/Province: _____

Date of last dental exam / cleaning: _____

Date of last dental x-rays? _____ May we request these? ☐ Yes ☐ No

How often do you get your teeth cleaned? 3 mos ☐ 4 mos ☐ 6 mos ☐ 9 mos ☐ 12 mos ☐

Please select YES or NO to the following questions:		
	(Select Yes or No)	
1. Are you fearful of dental treatment?	☐	☐
2. Do your gums bleed when brushing, flossing or eating?	☐	☐
3. Have you experienced gum recession?	☐	☐
4. Do you have difficulty brushing or flossing an area? Does food get stuck?	☐	☐
5. Do you have a bad taste/odor in your mouth?	☐	☐
6. Do you have any loose teeth, or noticed any teeth moving/shifting?	☐	☐
7. Do you or have you ever smoked/chewed tobacco? How much per day? _____ When did you quit? _____	☐	☐
8. Do you floss, use water jet, interdental stimulator, or proxy brush?	☐	☐
9. Have you experienced a burning sensation in your mouth?	☐	☐
10. Do you have toothaches, sore teeth or dental pain?	☐	☐
11. Are your teeth sensitive to hot / cold / sweets / biting / or touch?	☐	☐
12. Do you avoid brushing any part of your mouth?	☐	☐
13. Do you have any broken teeth, missing fillings, or root canals?	☐	☐
14. Do you have a dry mouth?	☐	☐
15. Do you drink fluoridated water or take fluoride supplements?	☐	☐
16. Have you had cavities treated or diagnosed in the past 2 years?	☐	☐
17. Have you ever had a dental implant?	☐	☐
18. Have you ever had periodontal (gum) surgery?	☐	☐
19. Do you wear dentures or partials? If yes how long have you had them? _____	☐	☐
20. Do you clench or grind your teeth?	☐	☐
21. Do you bite your lips / cheeks regularly?	☐	☐
22. Do you have soreness/pain in jaw, ear, or side of face (TMJ disorder)	☐	☐
23. Do you have any sores or lumps in your mouth?	☐	☐
24. Do you get frequent headaches?	☐	☐
25. Does your jaw ever pop, click, lock, or become tired?	☐	☐
26. Do you have difficulty opening, closing or chewing certain types of food?	☐	☐

NOVO DENTAL CENTRE

Dental History Continued

Please select YES or NO to the following questions:		
27. Do your teeth come together unevenly?	☐	☐
28. Do you wear a splint, night guard or have had a neck injury?	☐	☐
29. Do you have stiff neck muscles?	☐	☐
30. Do you awaken with an awareness of your teeth or jaw?	☐	☐
31. Do you have any problems chewing gum?	☐	☐
32. Do you like the way your teeth look? If no, why? _____	☐	☐
33. Are you happy with the colour of your teeth?	☐	☐
34. Have you ever whitened your teeth?	☐	☐
35. Would you like for your teeth to be whiter?	☐	☐
36. Do you have chips/spaces/crowded or crooked teeth that bother you? If yes, please specify: _____	☐	☐
37. Is there anything about the appearance of your teeth that you would like to change? If yes, what would you like to change? ☐ Upper Teeth ☐ Lower Teeth ☐ Both ☐ Length ☐ Shape ☐ Alignment ☐ Other _____	☐	☐
38. Do you have missing teeth that you would like to replace?	☐	☐
39. Do you have existing dental work you would like replaced? If yes, please explain: _____	☐	☐
40. Do you feel you show too much gum when you smile?	☐	☐
41. Are you self-conscious of your teeth or smile?	☐	☐
42. Have you ever had braces before? If yes, date of completion: _____ Do you wear retainers? _____	☐	☐

Have you ever been in a motor vehicle accident or experienced any trauma to your jaw? ☐ Yes ☐ No

- If yes, please describe: _____

_____

Have you ever had trouble getting numb or had a reaction to local anesthetic(dental freezing) ☐ Yes ☐ No

- If yes, please describe: _____

_____

Have you ever had any complications with dental treatment: ☐ Yes ☐ No

- If yes, please describe: _____

NOVO DENTAL CENTRE

☐ Any additional comments or concerns about your mouth or teeth: _____

_____

_____

_____

Dentist's Notes:

_____

_____

_____

_____

_____

_____

I also give consent to ANY advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or his/her staff for diagnostic purposes or dental treatment. These records may include study models, photographs and x-rays.

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Submit Form