

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: _____

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

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

Medical History Continued

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

Medical History Continued

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

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: _____

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do your gums bleed when brushing, flossing or eating? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you experienced gum recession? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have difficulty brushing or flossing an area? Does food get stuck? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have a bad taste/odor in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any loose teeth, or noticed any teeth moving/shifting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you or have you ever smoked/chewed tobacco? How much per day? _____ When did you quit? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you floss, use water jet, interdental stimulator, or proxy brush? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you experienced a burning sensation in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | |
| 10. Do you have toothaches, sore teeth or dental pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are your teeth sensitive to hot / cold / sweets / biting / or touch? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you avoid brushing any part of your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have any broken teeth, missing fillings, or root canals? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you have a dry mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you drink fluoridated water or take fluoride supplements? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you had cavities treated or diagnosed in the past 2 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had a dental implant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had periodontal (gum) surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you wear dentures or partials? If yes how long have you had them? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| | | |
| 20. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you bite your lips / cheeks regularly? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you have soreness/pain in jaw, ear, or side of face (TMJ disorder) | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you have any sores or lumps in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you get frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Does your jaw ever pop, click, lock, or become tired? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you have difficulty opening, closing or chewing certain types of food? | <input type="checkbox"/> | <input type="checkbox"/> |

Dental History Continued

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

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

o If yes, please describe: _____

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

o If yes, please describe: _____

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

o If yes, please describe: _____

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: _____

Please Email Form to info@novodentalcentre.com