NOVO DENTAL CENTRE

Child / Emerg Registration Form

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

Date: _____ Gender: M / F (Circle One)

Name: _____ Preferred Name: _____

Parent/Guardian's Name: _____ Relationship: _____

Birthdate: _____ Email Address: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

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

❑ Work Number: _____ ❑ Cell Number: _____

Spouse: _____ (circle one) Married / Single / Divorced / Widowed

Getting to know you:

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: _____

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Medical History

Patient Name: _____ Preferred Name:_____

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

What is your estimate of your general health: (circle one) Poor / Fair / Good

Had you ever had the following? (Circle yes or no)

- Have you ever had a serious illness requiring hospitalization or surgery? Yes No
  If yes, please describe:_____
- Are your currently seeing your family doctor or specialist for any condition? Yes No
  If yes, please describe:_____
- List any prescriptions or non-prescription medicine you take regularly.
  _____
  _____
- Do you have any allergies? Yes No
  If yes, please list:_____
- Have you been warned against taking any drug or medication? Yes No
  If yes, please list:_____
- Please list any medical conditions, past or present (i.e. heart attack, joint replacement, diseases, disorders) _____
- Do you bruise easily or bleed abnormally? Yes No
- WOMEN ONLY: Are you pregnant or nursing? Yes No
  Are you taking birth control pills? Yes No
  Are you taking any medications for osteoporosis? Yes No

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

_____

List any medication taken within the last two years:

_____

_____

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

Patient/Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____