NOVO DENTAL CENTRE

Client Registration

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

Date: _____ Gender: M / F (circle one)

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: _____ (circle one) 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: (circle one) Excellent / Good / Fair / Poor

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

NOVO DENTAL CENTRE

Medical History Continued

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

NOVO DENTAL CENTRE

Medical History Continued

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

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

NOVO DENTAL CENTRE

Dental History Continued

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

- 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: _____

- 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: _____

NOVO DENTAL CENTRE

To Our Valued Patients - Rescheduling and No Show Information

We appreciate that it may become necessary to reschedule an appointment. Please understand that this appointment has been reserved specifically for you. In order to accommodate the needs of our patients we ask for two business days' notice in order to change your appointment.

The reason why we ask for 2 business days' notice is because we have a number of patients on our "priority list". They require appointments on short notice as they are suffering or in pain. If we do not receive appropriate notice we cannot schedule them in within the time frame they need. It is very important to our doctors that we see them as quickly as possible.
Each person's situation is different and we realize that family, office emergencies, and illness can arise. We will be pleased to discuss the details of short notice appointment changes on an individual basis.

Our doctors and staff look forward to taking care of your oral health needs and welcome you and your family to our team of dental professionals.

Dental Benefits Update

As a service to our patients we will continue to bill your dental benefit plan directly, however, we want to update you with some of the challenges that we are experiencing with a number of insurance companies.

1. Due to the Privacy Act and the fact that the dental office is third party we are often unable to obtain our patients' personal information. If *your* insurance company will not provide our dental office with your benefit information we encourage you to speak to your carrier regarding the coverage of your plan to avoid any disappointment if there is a decline in payment of treatment.

2. We are finding that dental benefits are changing rapidly with some reductions in your coverage. Unfortunately, Insurance companies do not inform the dental offices of changes to your policy.

3. Often, your dental benefits will not cover the exact percentage of your treatment – for example limits have been reached, lab fees or payments for molar restorations exceed what your plan will allow, a clause in your plan that you are not aware of. We do our best to provide you with an estimate, however, we find that because of information we are unaware of the estimate may not be accurate.

4. I authorize release of personal information, to my benefits plan administrator and CDA, information contained in claims submitted electronically to be payable to the assigned Dentist. This authorization shall continue in effect until the undersigned revokes the same.

   Also, please note any treatment that your insurance does not pay or exceeds the limit of your individual plan will be your responsibility and billed directly to you.

_____ _____

Patient Signature Date