NOVO DENTAL CENTRE

Returning 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

Updated 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

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Updated 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

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Updated 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: _____