PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

1. A
If this appointment is for you start here

DATE
NAME
SPOUSE
ADDRESS
CITY | PROV | POSTAL CODE
RESIDENCE NO. | BUSINESS NO.
BIRTHDAY | AGE
MARRIED | SINGLE | DIVORCED | WIDOWED

1. B
If this appointment is for your child start here

DATE
NAME
SPOUSE
ADDRESS
CITY | PROV | POSTAL CODE
RESIDENCE NO.
BIRTHDAY | AGE
SCHOOL

IF YOUR CHILD'S NAME AND ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE ABOVE BOX ALSO.

2

DENTAL INSURANCE

PRIMARY CARRIER
INSURANCE CO.
EMPLOYEE
EMPLOYER
GROUP NO.
SOCIAL INSURANCE NO.
I.D. NO. OR CERTIFICATE NO.
EMPLOYEE DATE OF BIRTH

SECONDARY CARRIER
INSURANCE CO.
EMPLOYEE
EMPLOYER
GROUP NO.
SOCIAL INSURANCE NO.
I.D. NO. OR CERTIFICATE NO.
EMPLOYEE DATE OF BIRTH

3

GETTING TO KNOW YOU

ARE ANY OTHER FAMILY MEMBERS PATIENTS AT OUR OFFICE?
REFERRED TO US BY
PERSON TO CONTACT FOR EMERGENCY
PHONE NO.
ADDRESS
CITY | PROV | POSTAL CODE

4

ACCOUNT INFORMATION
(PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT)

NAME
ADDRESS
CITY | PROV | POSTAL CODE
RESIDENCE NO. | BUSINESS NO.
OCCUPATION
EMPLOYER

Date:_____

HEALTH HISTORY

1. Do you have a physician — family or otherwise you see on a regular basis? ☐Yes ☐No
   Physician's Name _____
   Address _____ Phone # _____
2. Are you under the care of a specialist? ☐Yes ☐No
   Physician's Name _____
   Address _____ Phone # _____
3. Is there any history of family disease? ☐Yes ☐No
4. Have you taken any medicine or drugs during the past two years? ☐Yes ☐No
   Are you taking any medication, drugs or pills? ☐Yes ☐No
   If yes please list:_____
5. Are you allergic or have you reacted adversely to any of the following medications? ☐Yes ☐No

Aspirin	Nitrous Oxide	Seafood	Valium	Rubber or Latex Products	Sleeping Pills
Darvon	Erythromycin	Fruit	Scopolamine	Penicillin	
Codeine	Tetracycline	Drugs	Local Anesthetic	Other Antibiotics	
Demerol	Percodan	Adhesive Tape	Nembutal/Seconal	Novocaine or Xylocaine	

6. Are you aware of being allergic to any other medications or substance? ☐Yes ☐No
   If yes please list:_____
7. Do you have frequent exposure to latex (rubber) products in your work? ☐Yes ☐No
8. Have you had a skin reaction or itching after using rubber objects (balloons, rubber gloves)? ☐Yes ☐No
9. Have you had frequent or extended times in hospital or multiple surgeries? ☐Yes ☐No
10. Circle any of the following which you have had or have at present:

Heart Failure	Kidney Trouble	Arthritis	Venereal Disease (Syphilis, Gonorrhea)
Heart Disease or Attack	Ulcers	Rheumatism	Cold Sores
Angina Pectoris	Cosmetic Surgery on Head/Neck	Cortisone Medicine	Fever Blisters
High Blood Pressure	Emphysema	Glaucoma	Epilepsy or Seizures
Heart Murmur	Cough	Pain in Jaw Joints	Fainting or Dizzy Spells
Rheumatic Fever	Tuberculosis (TB)	Alcohol Addiction	Nervousness
Congenital Heart Lesions	Asthma	HIV Positive	Psychiatric Treatment
Scarlet Fever	Hay Fever	Hepatitis A (Infectious)	Sickle Cell Disease
Artificial Heart Valve	Sinus Trouble	Hepatitis B (Serum)	Bruise Easily
Heart Pacemaker	Allergies or Hives	Liver Disease	Lupus
Heart Surgery	Diabetes	Yellow Jaundice	
Artificial Joints (Hip, Knee)	Thyroid Disease	Blood Transfusion	
Anemia	X-ray or Cobalt Treatment	Drug Addiction	
Stroke	Chemotherapy (Cancer, Leukemia)	Hemophilia	

Patient has been explained and comprehends all the questions _____ Initials

11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ☐Yes ☐No
12. Do your ankles swell during the day? ☐Yes ☐No
13. Do you use more than 2 pillows to sleep? ☐Yes ☐No
14. Have you ever experienced problems with healing? ☐Yes ☐No
15. Do you ever wake up from sleep short of breath? ☐Yes ☐No
16. Are you on a special diet? ☐Yes ☐No
17. Has your medical doctor ever said you have a cancer or tumor? ☐Yes ☐No
18. Do you have any disease, condition, or problem not listed? ☐Yes ☐No

FOR WOMEN ONLY:

Are you pregnant? ☐Yes ☐No If yes, what month? _____ Are you taking birth control pills? ☐Yes ☐No

FOR EVERYONE — ABOVE INFORMATION IS TRUE Patient Signature _____

DATE	COMMENTS/UPDATES