WELCOME TO OUR OFFICE

PATIENT REGISTRATION & HEALTH HISTORY *MEDICAL ALERT*

Last name:	First Name:	Birth date:	Female ( ) Male ( )
Address:			
City:	Province:	Postal Code:	
Home # ( )	Cell # ( )	Work # ( )	
Email Address:		Alberta Health Card #	
Referral Source:			

Health History:

1. Have you had a medical examination in the past year? **yes** □ **no** □
2. Have you been a patient in the hospital in the past two years? **yes** □ **no** □
3. Please state your physician's name: _____ Phone #: _____
4. Please list all medications you are on at this time: _____
_____
5. For WOMEN only: Are you pregnant? **yes** □ **no** □ If **yes**, what month? _____
6. Are you currently taking birth control pills? **yes** □ **no** □

Are you allergic, or have you reacted to any of the following medications? Please CIRCLE those which apply to you:

Acetaminophen (Tylenol)	Demerol	Lorazepam (Ativan)	Percocet
Aspirin	Diazepam (Valium)	Nitrous Oxide	Sleeping Pills
Codeine	Erythromycin	Novacain	Triazolam (Halcion)
Clindamycin	Local Anesthetic	Penicillin	Other Antibiotics

Are you aware of being allergic to any other medications or substances? **yes** □ **no** □ If **yes**, please list:

Do you have any of the following conditions or illnesses? Please CIRCLE those which apply to you:

AIDS	Cortisone/Steroid Meds	Haemophilia	Radiation/Chemotherapy
Allergies/Hives	Diabetes	Hepatitis A/B/C	Scoliosis
Angina Pectoris	Drug Addiction	Herpes	Scarlet Fever (back problems)
Anemia	Emphysema	High/Low blood pressure	Sickle Cell Disorder
Artificial Heart Valve	Epilepsy/Seizures	HIV Positive	Sinus Trouble
Artificial Joints	Fainting/Dizzy Spells	Kidney Trouble	Stomach Problems
Arthritis/Rheumatism	Fever Blisters	Liver Disease	Stroke
Asthma	Glaucoma	Lung Disease	Thyroid Disease
Blood Disorders	Hay Fever	Mitral Valve Prolapse	Tuberulosis (TB)
Bruise Easily	Heart Disease/Attack	Organ Transplant	Ulcers
Cancer	Heart Failure/Murmur	Persistent Cough	Undiagnosed Skin Rash
Cold Sores	Heart Pacemaker	Persistent Diarrhea	Venereal Disease
Congenital Heart Lesions	Heart Surgery	Psychiatric Disorders	Yellow Jaundice

If you have any disease, condition or illness not listed above, please list:

Dental History:

1. Have you had regular dental exams in the past? **yes** □ **no** □
2. When was your last dental visit? _____
3. What was done? _____
4. Have you ever had abnormal bleeding or other problems associated with dental extraction or surgery? **yes** □ **no** □
5. Have you had any complication with local anesthetic (freezing)? **yes** □ **no** □
6. Are you having dental pain? **yes** □ **no** □
7. Have you noticed loosening teeth? **yes** □ **no** □
8. Is food catching between your teeth? **yes** □ **no** □
9. Do you have pain/swelling of gums? **yes** □ **no** □
10. Do you have any oral habits such as clenching or grinding, nail biting or sucking your thumb? **yes** □ **no** □
11. Do you notice bad breath? **yes** □ **no** □
12. Have you ever experienced headaches upon awakening? **yes** □ **no** □
13. Do you smoke? **yes** □ **no** □
If yes, How many per day? _____
14. Are you happy with the look of your teeth? **yes** □ **no** □
15. Have you ever had professional dental hygiene instruction on brushing and flossing? **yes** □ **no** □
16. Do you brush daily? **yes** □ **no** □
17. Do you floss daily? **yes** □ **no** □
18. Do your gums bleed when brushing? **yes** □ **no** □
19. Do your gums bleed when flossing? **yes** □ **no** □
20. Do your gums bleed spontaneously? **yes** □ **no** □

This is to certify that I, _____ consent to the performing of the dental and oral surgery procedures agreed to be necessary or advised, including the use of general or local anesthetics as indicated and I will assume responsibility for fees associated with those procedures including those fees which are not covered by any insurance I may be covered by at any given time. I agree that the information pertaining to my health is true to the best of my knowledge at this time.

_____ _____ Patient □ Parent □ Guardian □

Date Signature *Please check applicable box*