BRONTE HILL
DENTAL CARE

PATIENT REGISTRATION

Prefix: ○ Dr. ○ Mr. ○ Mrs. ○ Ms. ○ Miss

Name: _____

Prefers to be called: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____

Business Phone: _____ Ext.: _____

Cell Phone: _____

E-Mail Address: _____

Date of Birth: _____ Age: _____ Sex: Please Select

Marital Status: Please Select Name of Spouse: _____

Are other family members patients with us? ○ Yes ○ No Name: _____

Where did you hear of us? ○ Google ○ Internet ○ Flyers ○ Other: _____

Family Physician: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Emergency Contact: _____ Phone: _____

PRIMARY DENTAL INSURANCE

Subscriber's Name _____ D.O.B. _____

Emp./Grp. policy holder _____

Ins. Co. _____ Tel. _____

Grp./Ind. policy No. _____ Cert. No. _____

I.D./S.I.N. _____

SECONDARY DENTAL INSURANCE

Subscriber's Name _____ D.O.B. _____

Emp./Grp. policy holder _____

Ins. Co. _____ Tel. _____

Grp./Ind. policy No. _____ Cert. No. _____

I.D./S.I.N. _____

BRONTE HILL
DENTAL CARE

MEDICAL HISTORY SECTION

1. INDICATE WHICH Of THE fOLLOWING YOU PRESENTLY HAv E OR Ev ER HAD:

A.I.D.S.	○ Yes ◉ No	Frequent headaches	○ Yes ◉ No	Liver disease	○ Yes ◉ No
Alcohol dependency	○ Yes ◉ No	Frequent throat infections	○ Yes ◉ No	Low blood pressure	○ Yes ◉ No
Anemia	○ Yes ◉ No	Glandular disorders	○ Yes ◉ No	Lung disease	○ Yes ◉ No
Angina pectoris	○ Yes ◉ No	Glaucoma	○ Yes ◉ No	Lupus	○ Yes ◉ No
Arthritis/rheumatism	○ Yes ◉ No	Hay Fever	○ Yes ◉ No	Malignant Hyperthermia	○ Yes ◉ No
Artificial heart valve	○ Yes ◉ No	Hearing difficulty	○ Yes ◉ No	Medical implant	○ Yes ◉ No
Artificial joints (hip, knee)	○ Yes ◉ No	Heart attack	○ Yes ◉ No	Mental/nervous disorder	○ Yes ◉ No
Asthma	○ Yes ◉ No	Heart disease	○ Yes ◉ No	Metal allergies	○ Yes ◉ No
Bleed or bruise easily	○ Yes ◉ No	Heart murmur	○ Yes ◉ No	Mitral valve prolapse	○ Yes ◉ No
Blood disorders	○ Yes ◉ No	Head/neck injuries	○ Yes ◉ No	Organ transplant	○ Yes ◉ No
Bronchitis	○ Yes ◉ No	Heart pacemaker	○ Yes ◉ No	Osteoporosis	○ Yes ◉ No
Cancer	○ Yes ◉ No	Heart rhythm disorder	○ Yes ◉ No	Psychiatric treatment	○ Yes ◉ No
Chemotherapy	○ Yes ◉ No	Heart surgery	○ Yes ◉ No	Radiation treatment	○ Yes ◉ No
Circulation problems	○ Yes ◉ No	Hepatitis A	○ Yes ◉ No	Rheumatic fever	○ Yes ◉ No
Congenital heart lesions	○ Yes ◉ No	Hepatitis B	○ Yes ◉ No	Shortness of breath	○ Yes ◉ No
Cortisone/steroid	○ Yes ◉ No	Hepatitis C	○ Yes ◉ No	Sickle cell disease	○ Yes ◉ No
Crohn's disease	○ Yes ◉ No	Herpes	○ Yes ◉ No	Sinus trouble	○ Yes ◉ No
Diabetes type I	○ Yes ◉ No	High blood pressure	○ Yes ◉ No	Skin rashes	○ Yes ◉ No
Diabetes type II	○ Yes ◉ No	H.I.V.	○ Yes ◉ No	Smoking	○ Yes ◉ No
Dramatic weight change	○ Yes ◉ No	Hodgkins disease	○ Yes ◉ No	Stomach problems	○ Yes ◉ No
Drug dependency	○ Yes ◉ No	Hyperglycaemia	○ Yes ◉ No	Stroke	○ Yes ◉ No
Emphysema	○ Yes ◉ No	Hypoglycaemia	○ Yes ◉ No	Swollen ankles/feet/hands	○ Yes ◉ No
Epilepsy or seizures	○ Yes ◉ No	Inflammatory bowel disease	○ Yes ◉ No	Hyperthyroidism	○ Yes ◉ No
Eyeglasses/contacts	○ Yes ◉ No	Intestinal problems	○ Yes ◉ No	Hypothyroidism	○ Yes ◉ No
Fainting or dizzy spells	○ Yes ◉ No	Jaundice	○ Yes ◉ No	Tuberculosis	○ Yes ◉ No
Food allergies	○ Yes ◉ No	Kidney disease	○ Yes ◉ No	Ulcers	○ Yes ◉ No
Frequent earaches	○ Yes ◉ No	Latex Allergies	○ Yes ◉ No	Other _____	

PLEASE ANSWER THE f OLLOWING QUESTIONS:

2. Has the CHILD PATIENT recently had:
   Chicken pox ○ Yes ◉ No
   Measles ○ Yes ◉ No
   Strep throat ○ Yes ◉ No
   Mumps ○ Yes ◉ No
   Tonsillitis ○ Yes ◉ No

3. **Women only:** Are you pregnant or suspect you may be? ○ Yes ◉ No Expected delivery date? _____
   Are you breast feeding? ○ Yes ◉ No Birth control pills? ○ Yes ◉ No

4. Have you ever been hospitalized? If so, please detail for what: _____

5. When was your last visit to a physician? _____ Last complete physical? _____

6. Are you taking any medication? If so, please detail: _____

7. Are you allergic to any medication? If so, please detail: _____

8. Do you currently have, or had in the past, any disease, condition or problem not listed above? _____

_____

BRONTE HILL
DENTAL CARE

DENTAL HISTORY SECTION

1. Is there a dental problem you would like treated immidiately? If so, please detail: _____

2. Date of your last dental visit? _____ Last dental cleaning? _____ Last x-rays? _____

3. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

Bleeding gums	○ Yes ◉ No	Emotional concerns for Dental treatment	○ Yes ◉ No	Nail biting	○ Yes ◉ No
Braces	○ Yes ◉ No	Food catching between teeth	○ Yes ◉ No	Painful gums	○ Yes ◉ No
Chewing pain	○ Yes ◉ No	Frequent bad breath	○ Yes ◉ No	Root canals	○ Yes ◉ No
Clenching appliance	○ Yes ◉ No	Frequent biting of cheeks	○ Yes ◉ No	Sensitive teeth to chewing	○ Yes ◉ No
Clenching your teeth	○ Yes ◉ No	Frequent biting of lips	○ Yes ◉ No	Sensitive teeth to cold	○ Yes ◉ No
Clicking jaw joint	○ Yes ◉ No	Grinding your teeth	○ Yes ◉ No	Sensitive teeth to sweets	○ Yes ◉ No
Complication during or after dental treatment	○ Yes ◉ No	Growths in your mouth	○ Yes ◉ No	Shifted teeth	○ Yes ◉ No
Dental implants	○ Yes ◉ No	Gum surgery	○ Yes ◉ No	Sore spots in your mouth	○ Yes ◉ No
Difficulty opening	○ Yes ◉ No	Jaw joint pain	○ Yes ◉ No	Swollen gums	○ Yes ◉ No
Difficulty closing	○ Yes ◉ No	Jaw surgery	○ Yes ◉ No	Wisdom teeth removed	○ Yes ◉ No
Difficulty chewing	○ Yes ◉ No	Loose teeth	○ Yes ◉ No	Other _____	
				Other _____	

4. Have you been advised to take antibiotics before a dental appointment? ○ Yes ◉ No

5. How often do you brush your teeth? _____

6. How often do you floss your teeth? _____

7. On a scale of 1 to 10 please rank your personal satisfaction with your oral health and smile Please Select

GENERAL RELEASE : TO BE SIGNED AT THE OFFICE

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical – dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these service.

X _____ _____

(signature) Patient ☐ Parent ☐ Guardian ☐ (print name of guardian)

Reviewed by Treating Dentist: _____ Date: _____