WELCOME TO OUR OFFICE

REGISTRATION INFORMATION

All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. of this form.

PATIENT INFORMATION

Last Name: _____
First Name: _____
Dr. ____ Mr.____ Mrs.____ Miss____ Ms.____
Address: _____
_____
___ _____

Home Phone: _____
Business Phone: _____
Mobile Phone: _____
E-mail Address: _____

Employer: _____
Occupation: _____
If student, ID No.: _____
In case of emergency, who shall we contact?

Language preferred: _____
Date of Birth: _____
Marital Status: _____

Name: _____
Phone No.: _____
Relationship: _____
Whom may we thank for referring you to our clinic? _____
Reason for today's dental visit: _____

FINANCIAL & CREDIT INFORMATION

Person responsible for Dental Fees:
Last Name: _____
First Name: _____
Relationship: _____
Date of Birth: _____
Social Ins. No. _____

How do you intend to pay for your fees?
Credit Card ___ Debit ___Cash___
Insurance ___ ODSP ___
Healthy Smiles ___ Other ___

Primary Dental Insurance
Subscriber's Name: _____
D.O.B.: _____
Ins. Co.: _____
Group Policy #: _____
Cert. No.: _____
Employer: _____

Secondary Dental Insurance
Subscriber's Name: _____
D.O.B.: _____
Ins. Co.: _____
Group Policy #: _____
Cert. No.: _____
Employer: _____

HEALTH HISTORY

Family Physician _____ Phone Number_____
Medical Specialist _____ Phone Number_____

1. Are you being treated for any medical condition at present or within the past year? Y__ N__
   If yes, please explain _____
2. Has there been any changes in your general health in the past year?_____ Y__N__
3. When was your last visit to a Physician? _____
4. Have you ever had any adverse or unusual reaction to any medications or injections?
   (e.g. penicillin, or other antibiotics, aspirin, codeine, local anaesthetic) Y__N__
   Please explain if yes _____
5. Are you taking any prescription drugs? List_____ Y__N__
6. Do you have any allergies (e.g. hay fever, food allergies, latex/rubber or metal)? Y__N__
7. Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders? Y__N__
8. Are you on cortisone or steroid therapy? Y__N__
9. Do you have any artificial joints (e.g. hip, knee)? Y__N__
10. Do you have a heart murmur, valve dysfunction (mitral valve prolapse, Or artificial heart valve) or have you ever had Rheumatic Fever? Y__N__
11. Have you ever been advised to take antibiotics before dental treatment? Y__N__

12. Do you have, or have you ever had, any heart or blood pressure problems (heart or stroke)? Y__N__
    Please explain_____
13. Have you ever had cancer, or are you presently undergoing any radiation treatment or chemotherapy? Y__N__
14. Indicate which of the following you presently have, or ever had:

___Asthma	___Epilepsy/Seizure	___Tuberculosis
___Glandular Disorders	___Bronchitis	___Hepatitis
___Diabetes	___Organ transplant/medical transplant	___Emphysema
___Jaundice	___Kidney Disease	___Liver Disease
___Lung Disease	___Stomach/Intestinal problems	___Thyroid Disease
___Ulcers	___Pacemaker	___HIV/AIDS

15. Do you, or did you smoke? How many cigarettes a day? _____ Y__N__
16. Do you drink alcoholic beverages on a regular basis? Y__N__
17. WOMEN ONLY. Are you pregnant? Y__N__
    If pregnant, delivery date? _____
    Are you breast feeding? Y__N__
18. Have you ever been hospitalized? Y__N__
19. Do you currently have, or ever had in the past, any disease, condition or problem Not listed above?_____ Y__N__

DENTAL HISTORY

Previous Dentist _____ Phone Number_____
Last dental visit _____ What was done_____

1. Are you having regular dental visits? Y__N__
2. Have you ever had any of the following?
   Periodontal Treatment (treatment of gums)? Y__N__
   Orthodontic Treatment (braces)? Y__N__
   Dental Implants? Y__N__
   Oral Surgery (e.g. wisdom tooth removal, or jaw surgery)? Y__N__
3. Are any of your teeth sensitive to heat, cold, sweets, or pressure? Y__N__

GENERAL RELEASE

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 my health status in the future, 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 and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for these fees associated with these services.

Patient Signature _____ Date_____

If under 18, Parent or Guardian _____ Date_____

I authorize the release of information contained in claims submitted electronically to my dental benefits plan administrator or insurance.

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Patsy Kwok and authorize payment directly to her/him.

_____ Signature of patient, parent or guardian

_____ Signature of subscriber

OFFICE POLICY

Your appointment time is reserved for you. Please provide 24 hours notice for cancellations. There is a **charge of $30 for cancellations with less than 24 hours notice**. Thank you.