Welcome to Centrum Dental

Your cooperation in completing this questionnaire is essential in providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. We will be glad to assist you with the completion of this form.

Date (MM/DD/YYYY): ____________________

REGISTRATION INFORMATION

Patient Name (Surname, Given) ________________________ Prefer to be called _____________
Home Address: ____
City: ___________________ Province: ___________ Postal Code: ___________________
Home Phone: ___________________ Work Phone: ___________________
Fax: ___________________ Other: ___________________
Birth Date (MM/DD/YYYY): ___________________ Sex: _______
E-Mail Address: ______________________________________

Emergency Contact: ___________________ Relationship to you: _____________________
Phone: _____________________

Parent or Guardian

Name (Surname, Given): _______________________ Relationship: ____________________
Home Address: ____
City: ___________________ Province: ___________ Postal Code: ___________________
Home Phone: ___________________ Work Phone: ___________________

***I understand that by accepting dental treatment today, I agree that Centrum Dental Centre may use my photo in future promotional materials. Initial: _______________

How did you hear about our Free Dentistry Day? ____________________________________

PATIENT RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medicaldental 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 history. I authorize my dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

Signature: ________________________________ Date (MM/DD/YYYY): __________________
☐ Patient ☐ Parent ☐ Guardian Reviewing
Dentist:______________________________________

Medical History

Date of last medical examination (MM/DD/YYYY): ___________________
Family physician Name: ____
City: ____________________ Phone: ________________
Are you currently undergoing treatment for any reason? If yes, Please explain:
____
Recently hospitalization (in last 3 years): ____
Have you had joint replacement surgery (knee, hip, etc.)? ☐ Yes When:_________________
List the medications that you are taking. Please specify the name of medication, dose, and frequency:
____
____
List any allergies you have to medications, food and other items:
____
____

Have you ever had or been treated for:

Constitutional:
- ☐ Recent fever/sweats
- ☐ Unexplained weight loss/gain
- ☐ Unexplained fatigue/weakness

Eyes
- ☐ Change in vision
- ☐ Glaucoma

Ears/Nose/Throat
- ☐ Difficulty hearing/ringing in ears
- ☐ Hay fever/allergies/congestion

Cardiovascular
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Short of breath on exertion
- ☐ High/Low Blood Pressure
- ☐ Stoke
- ☐ Chest pains/discomfort

Blood disorders/Lymphatic
- ☐ Easy bruising/bleeding
- ☐ Unexplained lumps
- ☐ Anemia
- ☐ History of sinus infections

Respiratory
- ☐ Cough/Wheeze
- ☐ Coughing up blood
- ☐ Asthma

Gastrointestinal
- ☐ Heartburn/reflex ☐ Bloody discharge
- ☐ Nausea/vomiting/diarrhea
- ☐ Ulcer

Musculoskeletal
- ☐ Arthritis
- ☐ Recent back pain
- ☐ Neck pain
- ☐ Muscle/joint pain

Neurological
- ☐ Headaches
- ☐ Memory Loss
- ☐ Fainting/Dizzy spells
- ☐ Epilepsy

Infectious Diseases
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Herpes
- ☐ AIDS or HIV +ve

Psychiatric
- ☐ Anxiety/stress
- ☐ Depression

Endocrine
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Thyroid problems
- ☐ High cholesterol
- ☐ History of Cancer

For Female Patients

Are you Pregnant? .... ☐ Yes ☐ No
Are you Nursing? .... ☐ Yes ☐ No
Are you taking birth control pills? .... ☐ Yes ☐ No