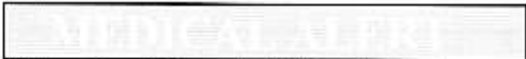


WELCOME TO OUR DENTAL OFFICE



The personal information provided below will be protected and kept private by our office. All information will be used and disclosed responsibly according to the Privacy Act standards set up and monitored by our office.

Mr. Mrs. Miss Ms. Dr. Given Name: _____ Marital Status: _____

Surname: _____ Pronunciation: _____ Prefer to be called _____

Address: (Street) _____ (Apt.#) _____ (City) _____ (Postal Code) _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ X _____ Date of Birth: ____ / ____ / ____

Fax: (____) _____ - _____ Other: (____) _____ - _____ X _____ Male Female Adult Child

Employer / School: _____ Occupation: _____

eMail Address: _____ Contact Method _____

Who may we thank for referring you to this office? _____

Are you likely to be available on short notice for future appointments? Yes No

Family Physician: _____ Phone: (____) _____ - _____

In Case of Emergency Notify: _____ Relation: _____ Phone: (____) _____ - _____

Person responsible for this account: Self Spouse Parent Legal Guardian Other: _____

Name: (Last) _____ (First) _____ (Initial) _____ Relation: _____

Address: (Street) _____ (Apt.#) _____ (City) _____ (Postal Code) _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ X _____ Business License Number _____

Primary Insurance	Secondary Insurance
Subscriber: _____ Date of Birth: _____	Subscriber _____ Date of Birth: _____
Relation: <input type="checkbox"/> Self <input type="checkbox"/> Spouse Other: _____	Relation: <input type="checkbox"/> Spouse Other: _____
Subscriber I.D. _____ SIN _____	Subscriber I.D. _____ SIN _____
Insurance Co: _____	Insurance Co: _____
Policy/Plan #: _____ Division/Sect. #: _____	Policy/Plan #: _____ Division/Sect. #: _____
Are You Familiar with Your Plan Details? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are You Familiar with Your Plan Details? <input type="checkbox"/> Yes <input type="checkbox"/> No

Method of Payment Cash Cheque Credit Card: _____ Number: _____ Exp.: _____

MEDICAL HISTORY ALL INFORMATION IS CONFIDENTIAL

The following information is required by the dentist to assist in proper diagnosis and treatment. YES NO

- Have you ever had a serious illness requiring hospitalization or extensive medical care?
Please specify: _____
- Are you presently under the care of a physician?
If so, please explain: _____
- Have you had a medical examination in the last year?
- Do you use any prescription or non-prescription drugs regularly?
Please specify: _____
- Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex?
- Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea?
Please specify: _____
- Have you been hospitalized in the last 5 years?
Please specify: _____
- Have you ever experienced any unusual reaction to any of the following? (Please circle)
local anaesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or
any other medicine? If so please explain _____
- Have you been warned against taking any drug or medication?
- Do you bruise easily or bleed abnormally?
- Do you require pre-medication for dental treatment?

PATIENT REGISTRATION PLEASE COMPLETE BOTH SIDES **MEDICAL / DENTAL HISTORY**

SOFTWARE COMPATIBLE PATIENT QUESTIONNAIRE - NAVILLUS™ FORM TRACKVOIES

- | | Yes | No | |
|---|--|--|--|
| 12. Have you ever had any organ implants or medical implants? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13. Have you ever fainted? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14. Do your ankles swell? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 16. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 17. Do you have A.I.D.S. or have you ever tested positive for H.I.V.? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 18. Do you have any of the following? Please check any that apply | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> Heart Murmur or Mitral Valve Prolapse
<input type="checkbox"/> Stomach / Intestinal Problems / Ulcers
<input type="checkbox"/> Joint Replacement (hip, knee, etc.)
<input type="checkbox"/> Mental or Nervous Disorder
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Hyper (hypo) Glycemia
<input type="checkbox"/> Cortisone/Steroid Therapy | <input type="checkbox"/> Malignant Hyperthermia
<input type="checkbox"/> Drug / Alcohol Dependency
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Lung Disease (i.e. Asthma)
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Arthritis or Rheumatism
<input type="checkbox"/> Scarlet or Rheumatic Fever
<input type="checkbox"/> Cancer / Chemotherapy | <input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Cold Sores
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Hepatitis A,B,C
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Herpes
<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Stroke
<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Diabetes |
| 19. Have you had any injury, surgery or x-ray therapy to your face or jaws? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 20. Do you have any disease, condition, or problem that you think the doctor should know about? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 21. WOMEN ONLY - Are you pregnant or suspect you might be? If so, what month are you in? _____ | <input type="checkbox"/> | <input type="checkbox"/> | |
| Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> | |

DENTAL HISTORY

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Reason for today's visit: <input type="checkbox"/> Exam <input type="checkbox"/> Cleaning <input type="checkbox"/> Emergency <input type="checkbox"/> Other _____ | | |
| Are you presently having dental pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there a dental problem you would like to take care of as soon as possible? | <input type="checkbox"/> | <input type="checkbox"/> |
| Please specify: _____ | | |
| 2. How frequently do you see your dentist? <input type="checkbox"/> 6 months <input type="checkbox"/> Yearly <input type="checkbox"/> Other _____ | | |
| Last dental visit: _____ | | |
| Last cleaning: _____ Full mouth series of x-rays: _____ | | |
| 3. How often do you brush your teeth? _____ Floss? _____ | | |
| 4. Do your gums bleed easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are your teeth sensitive to: <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Biting <input type="checkbox"/> Sweets? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you feel you have bad breath at times? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had jaw joint surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have pain in your jaw joints or suffer from migraine headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does any part of your mouth hurt when clenched? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does your jaw crack or pop when opened widely? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had: <input type="checkbox"/> Braces <input type="checkbox"/> Oral surgery <input type="checkbox"/> Gum treatment <input type="checkbox"/> Root canal | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you grind or clench your teeth during the day or night? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you smoke? Number per day: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you or does any family member have a problem with snoring? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever experienced any growths or sore spots in your mouth? If so, where? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Previous problems with dental treatment? Specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you satisfied with the appearance of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Please specify: _____ | | |
| 18. Other Dental Concerns: _____ | | |

Privacy Act Notification: I have been informed of the privacy policy of this office and understand that all information I have supplied will be used and disclosed as set out within this office policy.

Office Policy: Your appointment time will be reserved for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it may be necessary to charge for the time lost.

Patient 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. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependants is mine, and I will assume responsibility for fees associated with these services.

 (Signature) PATIENT PARENT GUARDIAN

Date: _____ REVIEWING DENTIST