WELCOME TO MAPLE PLACE DENTAL CENTRE

PATIENT REGISTRATION & HEALTH HISTORY *MEDICAL ALERT*

Mr/Mrs/Ms/Miss Last Name:	First:	Birthdate:	Female( ) Male( )
Address:			
City:	Province:	Postal Code:	
Home # ( )	Work #( )	Cell #( )	
Email:		**How did you hear about us:**	
Preferred contact method: ❑ Home ❑ Work ❑ Cell ❑ Email		Do you have Dental Insurance? Yes / No	
How would you like to receive appointment reminders? ❑By Phone ❑By Email ❑By Text Message			

Health History:

1. Have you had a medical examination in the last year?----------Yes / No
2. Have you been a patient in the hospital during the past two years?----------Yes / No
3. Please state your physician's name: _____ Phone: _____
4. Please list all the medications you are on now: _____
5. Are you a smoker? Yes / No If yes, how long have you been a smoker?_____ How many per day?_____
6. **For WOMEN only**: Are you pregnant? YES / NO If yes, what month_____
7. Are you taking birth control pills? YES / NO

Are you allergic or have you reacted to any of the following medications? Please circle which ones:

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

Are you aware of being allergic to any other medications or substances?----------YES / NO

Circle all of the following which you have/undergone:

AIDS	Congenital Heart Lesions	Heart Pacemaker	Psychiatric Disorders
Allergies/Hives	Cortisone/Steriod Meds	Heart Surgery	Radiation/Chemotherapy
Angine Pectoris	Diabetes	Hemophilia	Scarlet Fever
Anemia	Drug Addiction	Hepatitis A/B/C	Sickle Cell Disorder
Artificial Heart Valve	Emphysema	Herpes	Sinus Trouble
Artificial Joints	Epilepsy/Seizures	High/Low Blood Pressure	Stomach Problems
Arthritis/Rheumatism	Fainting/Dizzy Spells	HIV Positive	Stroke
Asthma	Fever Blisters	Kidney Trouble	Thyroid Disease
Blood Disorders	Glaucoma	Liver Disease	Tuberculosis (TB)
Bruise Easily	Hay Fever	Lung Disease	Ulcers
Cancer	Heart Disease/Attack	Mitral Valve Prolapse	Venereal Disease
Cold Sores	Heart Failure/Murmur	Organ Transplant	Yellow Jaundice

If you have any disease, condition or problem not mentioned 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 previous dental extractions or surgery? YES / NO
5. Have you ever had Local Anesthetic? YES / NO
6. Are you having dental pain? YES / NO
7. Are you happy with the appearance of your teeth? YES / NO
8. Do you have any oral habits such as clenching or grinding, nail biting or sucking your thumb? YES / NO
9. Have you ever had professional tooth brushing and flossing instruction? YES / NO
10. Do you brush daily? YES / NO
11. Do you floss daily? YES / NO
12. Do your gums bleed when brushing? YES / NO
13. Do your gums bleed when flossing? YES / NO
14. Do your gums bleed spontaneously? YES / NO
15. Have you had any problems with or unpleasant reactions to dental treatment? YES / NO

Consent

1. I certify that the above information is correct to the best of my knowledge.
2. I authorize the doctor upon consultation and direct consent from the patient/parent/guardian to perform diagnostic procedures, treatment and medication in the connection with the patients dental needs.
3. I understand that responsibility for payment of dental services, including insurance or otherwise, is due and payable at the time services is rendered and despite any dental insurance, I am ultimately responsible for any fees withheld by the insurance company.

Date: _____ Signature: _____ Patient( ) Parent( ) Guardian( )
(please mark "X" which one applies)

Please see office policy regarding your Dental Insurance