

# WELCOME TO OUR DENTAL OFFICE

(For office use only)

Date \_\_\_\_\_

I.D. #	_____
MEDICAL ALERT Y <input type="checkbox"/> N <input type="checkbox"/>	

The information that is requested on this Questionnaire, Dental History and Medical History is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly. **PLEASE PRINT.**

**REGISTRATION INFORMATION** - This information will enable us to maintain communication with you.

The patient is an: Adult  Child  Adult under guardianship  Name of Guardian: \_\_\_\_\_

Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (initial) \_\_\_\_\_ Dr.  Mr.  Mrs.  Ms.  Miss

Prefers to be called: \_\_\_\_\_ Language Preference: \_\_\_\_\_

Address: (street) \_\_\_\_\_ (apt.#) \_\_\_\_\_ (city) \_\_\_\_\_ (province) \_\_\_\_\_ (postal code) \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Bus. Phone: ( ) \_\_\_\_\_ Ext.  Employer: \_\_\_\_\_ May we call you at work?

Cell Phone: ( ) \_\_\_\_\_ Pager No: ( ) \_\_\_\_\_ E-Mail address: \_\_\_\_\_

Date of Birth: M\_\_\_\_D\_\_\_\_Y\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_

Preferred appointment time: \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Are other family members patients at our office? Yes  Names: \_\_\_\_\_

**MEDICAL PRIORITY** - This information will enable us to make any essential contacts.

Family Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Medical Specialist: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
(if presently under care)

In case of emergency, please contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Nearest relative not living with you: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Reason for today's visit? Examination  Emergency  Other  \_\_\_\_\_

Is there a dental problem you would like treated immediately? \_\_\_\_\_

**FINANCIAL INFORMATION** - Please complete all information if different than above.

Person responsible for account: Self  Spouse  Other

Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (initial) \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: (street) \_\_\_\_\_ (apt.#) \_\_\_\_\_ (city) \_\_\_\_\_ (province) \_\_\_\_\_ (postal code) \_\_\_\_\_

Employed by: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

PRIMARY DENTAL INSURANCE				SECONDARY DENTAL INSURANCE			
(If information required by office)				(If information required by office)			
Subscriber's name:	_____	D.O.B.	_____	Subscriber's name:	_____	D.O.B.	_____
Ins. Co.	_____	Tel.	_____	Ins. Co.	_____	Tel.	_____
Grp. / policy No.	_____	ID / Cert. No.	_____	Grp. / policy No.	_____	ID / Cert. No.	_____

**PATIENT REGISTRATION**

**DENTAL HISTORY**