Patient Registration

Welcome, thank you for choosing us for your prosthetic treatment. We will strive to do our best to provide you with the finest care. If you have any questions about our office or this form, please do not hesitate to ask.

PERSONAL INFORMATION

Name: _____ Prefix: _____

Birthdate: _____ Age: _____ Gender: _____ Email: _____

Home Address: _____ City: _____ Province: _____

Postal Code: _____ Tel 1: _____ Tel 2: _____

Occupation: _____ Employer: _____ Work Phone: _____

Spouse's Name: _____

Who will accept responsibility for payment of your account? _____

Address: _____

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

Do you have a General Dentist? _____ Name: _____

HEALTH HISTORY

Family Physician: Name: _____ Phone: _____

Have there been any problem in your general health within the past 5 years? (serious illness, hospitalization, surgery?)

_____ If so, what was the problem? _____

Do you smoke? _____ Number of packs a day: _____

DO YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

	Yes/No		Yes/No
Rheumatic fever, rheumatic heart disease		Kidney Trouble	
Heart trouble, heart attack, high blood pressure, stroke		Diabetes	
Radiation or treatment for a tumour or other growth		Psychiatric disorders	
Blood disorders, anemia		Special needs	
Abnormal bleeding, prolonged healing		Asthma, hayfever	
Fainting spells, seizures		Low blood pressure	
Migraine or tension headaches		Artificial joint(s)	
Hepatitis, jaundice, liver disease		Women: Pregnant?	
AIDS-autoimmune deficiencies		Osteoporosis	
Sleep Apnea			

Any other medical condition that we should be aware of?

_____

_____

What medications do you take (including aspirin, etc)?

_____

_____

Are you allergic to any medications or substances (ie. latex)?

_____

_____

Do you require antibiotics prior to any dental treatment? _____

Do you react to local anesthetic? _____

Emergency contact person: _____ Phone: _____

ORAL HEALTH

Yes/No

Do you have pain around your ears, eyes or other parts of the face?

Do you clench or grind your teeth while awake or as leep?

Are you aware of any sores or lumps in your mouth at present?

Do you ever hear grating or popping sounds from your jaw joint?

IMPLANTS

Do you have implant(s)? _____ Date of Placement: _____

Name of the surgeon who placed the implants: _____

PATIENTS WITH FULL OR PARTIAL DENTURES

1. Please indicate the type of denture you wear: Partial: _____
   Full: _____

2. Do you have any problems with your full or partial dentures? _____

   If so, please describe:

   _____
   _____
   _____

3. When were your existing denture(s) made? Upper: _____ Lower: _____

4. Are you satisfied with the appearance of your dentures? _____

5. Are you interested in information on IMPLANTS to replace your dentures? _____

When receiving dental treatment, would you consider yourself to be:

_____

What are your dental problems?

_____
_____
_____

What concerns you the most about receiving dental therapy?

_____
_____
_____

Please be advised that your records may be shared with another dental office if a registration is required for your dental treatment, and only required information will be forwarded to your insurance company.

Should you need to reschedule or cancel your appointment, we require 2 business days notice to avoid a late fee.

Payment is expected at the time the services are rendered or initiated. Our office does not take assignment on insurance plans, but we are happy to fill out your documents so that you are able to submit for any coverage that your plan may provide. We accept cash, Visa, MasterCard and Debit.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status; if ever I have any change in my health condition or the medications I take, I will inform the Doctor on my next appointment without fail. I also understand that I am fully responsible for the financial aspect of my dental treatment to Anh Nguyen Dentistry Professional Corporation.

Signature of Patient, Parent or Legal Guardian: _____ Date: _____