PRECISION DENTISTRY

Dr. Navi Boparai

New Patient Registration

Name _____ _____
First Last Preferred Name

Address: _____ City: _____

Prov: ___ Postal Code: _____ Date of birth (dd/mm/yyyy):_____ Sex: M / F

Phone Number: Home: _____ Cell_____ Email: _____

Best contact method: _____ Personal Health Number: _____

In case of Emergency Contact Name:_____ Phone number:_____

Emergency Contact Relationship: _____ Work phone number:_____

Employer: _____ Occupation: _____

Do you have Dental Insurance? Y / N How did you hear about our office:_____

Dental History

Please circle or mark the correct response and provide additional information where indicated.

Are you having pain at this time? Y N _____

Have you ever had complications related to dental treatment? Y N _____

Do you have any dental implants? Y N _____

Are you aware of any loose teeth? Y N _____

Does food tend to get caught between your teeth? Y N _____

Are you satisfied with the appearance of your teeth? Y N _____

Are you nervous about having dental treatment? Y N

Are any of your teeth sensitive to: cold ❑ sweets ❑ heat ❑ other ❑ N/A ❑

Do your gums bleed when: Brushing ❑ Flossing ❑ N/A ❑

Have you ever had any of the following: Oral Surgery ❑ Periodontal Treatment ❑

Orthodontic Treatment ❑ Bite Adjustment ❑ Night Guard ❑ Other Appliance: _____

Name of previous dental office: _____ Phone number: _____

Have you had xrays in the last year?: _____

Health History

Please fill out the following information to the best of your abilities.

Physician's Name: _____Phone Number: _____

Are you allergic, or have you reacted adversely, to any of the following?

Aspirin	Y N	Codeine	Y N	Clindamycin	Y N
Darvon	Y N	Demerol	Y N	Erythromycin	Y N
Latex	Y N	Local Anesthetic	Y N	Mint Flavoring	Y N
Penicillin	Y N	Sulfa Drugs	Y N	NSAIDs	Y N

Taking Blood Thinners? Y N Have a pacemaker? Y N

Any Allergies Not listed: _____

Please list all medication you are taking now, including non-prescription medication (vitamins, cold medications, aspirin, Tylenol, antihistamines, herbal remedies, etc.): _____

_____

Do you have/or have you experienced any of the following:

AIDS/HIV	Y N	Crohn's Disease	Y N	Liver Disease	Y N
Allergies/Hay Fever	Y N	Cardiopulmonary Shunt	Y N	Lung Disease	Y N
Anemia	Y N	Diabetes	Y N	Lupus	Y N
Angina	Y N	Drug Addiction	Y N	Mitral Valve Prolapse	Y N
Angioplasty Pacemaker	Y N	Eating Disorder	Y N	Multiple Sclerosis	Y N
Artificial Joints	Y N	Emphysema	Y N	Parkinson's Disease	Y N
Arthritis	Y N	Epilepsy	Y N	Psychiatric Disorder	Y N
Asthma	Y N	Glaucoma	Y N	Rheumatic Fever	Y N
Artificial Heart Valve/Stent	Y N	Heart Murmur	Y N	Scarlet Fever	Y N
Blood Transfusion	Y N	Hepatitis A/B/C	Y N	STD's	Y N
Cold Sores	Y N	Hemophilia	Y N	Stroke	Y N
Chronic Fatigue Syndrome	Y N	High Blood Pressure	Y N	Tuberculosis	Y N
Congestive Heart Failure	Y N	Kidney Disease	Y N	Ulcers	Y N
				Ulcerative Colitis	Y N

Do you have any disease, condition or problem not listed? Y N
Do you wish to speak privately to the doctor about any medical condition? Y N
Have you had a medical examination in the last year? Y N
Have you been a patient in the hospital in the last 2 years? Y N
Have you had Cancer? Y N if yes, location _____
Did you complete Radiation or Chemo Therapy? Y N if yes, when _____
When walking, do you ever stop because of pain in your chest? Y N
Have you suffered from a Heart Attack ? Y N if yes, when:_____
Do your ankles swell during the day? Y N
Do you have a tendency to faint? Y N
Do you have frequent, severe headaches? Y N Frequency? _____
Do you use tobacco? Y N How Much?_____
Are you pregnant or possibly pregnant? Y N
Are you breastfeeding? Y N

I, the undersigned, hereby certify that all the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status. I understand that it will be kept strictly confidential. I consent to the performing of the dental procedures to be necessary or advisable including the use of local anaesthetics. I am also aware that although this office has agreed to deal with my dental plan, any claims made on my behalf which have not paid become my responsibility.
Our office requires 48 hour notice to cancel or reschedule an appointment otherwise a cancellation fee will be applied.

_____ _____ _____

Patient Name (Print) Patient/Guardian Signature Date (dd/mm/yyyy)