PATIENT REGISTRATION **WELCOME TO OUR OFFICE** *ALL INFORMATION IS CONFIDENTIAL*

Please feel free to ask the receptionist for help in completing this form. ***PLEASE PRINT***

PATIENT

Dr. ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Miss.** ☐ **Child** ☐

Name:_____
(last) (first) (initial) (preferred)

Address_____
(street) (city) (province) (postal code)

Email address:_____

NAMES AND ADDRESSES OF PARENTS OR GUARDIANS
Names_____
Address, if different from above_____

PERSONAL INFORMATION OF PATIENT
Date of birth_____ Marital status_____ Sex_____
(day/ month/ year)
Home phone #_____ Work phone # _____ Cell phone #_____
Employed by_____ your occupation_____
Name of spouse_____ spouse's date of birth_____
Spouse employed by_____ spouse's work phone # _____

INSURANCE INFORMATION
Dental insurance Yes ☐ No ☐ Who holds the insurance policy (ie. self or spouse)_____
Name of insurance company_____
Group policy #_____ Certificate or ID# _____

Is there a second insurance Yes ☐ No ☐ Who holds this insurance policy_____
Name of insurance company_____
Group policy #_____ Certificate or ID# _____

MEDICAL INFORMATION

Physician_____ Phone #_____
Medical Specialist (if under present care)_____ Phone #_____
In case of emergency, please notify_____ Phone #_____

Whom may we thank for referring you?_____
Is another member of your family or relative a patient at our office? _____
Reason for today's visit: emergency ☐ examination ☐
other_____
Is there a dental problem you would like to have taken care of as soon as possible?
_____
_____

DENTAL HISTORY

Date_____
M D Y

MEDI ALERT	

How frequently do you see your dentist? 6 months ☐ yearly ☐ other _____
Last dental visit:_____ Last cleaning: _____ Last full mouth series of xrays:_____
Have you been given oral hygiene instruction in: brushing ☐ flossing ☐ other:_____
Are any of your teeth sensitive to: cold ☐ sweets ☐ heat ☐ other:_____
Do your gums bleed when: brushing ☐ flossing ☐ spontaneously ☐
Have you ever had any of the following: *(please circle)* oral surgery, periodontal treatment, orthodontic treatment, bite adjustment, or other appliance– specify:_____

	CIRCLE	
Do you have dental implants	YES	NO
Do you suffer from pain and/or swelling of your gums	YES	NO
Are you aware of any loose teeth? If so, where?	YES	NO
Do you chew on only one side of your mouth? If so, why?	YES	NO
Habits, do you - grind or clench your teeth during the day or night?	YES	NO
- mouth breathe while awake or asleep?	YES	NO
- bite your lips or cheeks regularly?	YES	NO
- hold any foreign objects with your teeth? (i.e. pipe, pencils, nails)	YES	NO
12. Does any part of your mouth hurt when clenched?	YES	NO
13. Does your jaw crack or pop when opened widely?	YES	NO
14. Do you have any difficulty in opening or closing your jaw?	YES	NO
15. Do you have any pain in your ears?	YES	NO
16. Do you gag easily?	YES	NO
17. Have you experienced any growth or sore spots in your mouth? If so, where?	YES	NO
18. Are you concerned with the appearance of your teeth, and if so what would you like to see changed?	YES	NO

Specify:_____

19. Would you rate your current dental health as: *(please circle)* Excellent Good Fair Poor
20. Is your sugar intake: *(please circle)* High Medium Low
21. Brushing: Vigorous ☐ Light ☐ How often:_____
22. Cleaning aids presently used: *(please circle)* floss, stimudents, toothpick, other_____
23. Do you have any emotional concerns regarding your dental visit? *(please circle)*
    Fear, pain, time, money, embarrassment, other concerns_____

I, the undersigned, certify that all the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary, as this information may be required for my dental care.
Patient (Parent, Guardian*) Signature:_____
Please print name:_____ Date:_____
M D Y

I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and will assume responsibility for fees associated with these procedures.
Patient (Parent, Guardian*) Signature:_____
Please print name:_____ Date:_____
(*Guardian of Child, or Guardian of Adult under Guardianship) M D Y

Medical History Questionnaire

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

- Are you being treated for any medical condition at the present or have you been treated within the past year. If so, why?
  _____ □ Yes □ No □ Not sure/Maybe
- When was your last medical check-up? _____
- Has there been any change in your general health in the past year? If yes please explain.
  _____ □ Yes □ No □ Not sure/Maybe
- Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If so please list.
  _____ □ Yes □ No □ Not sure/Maybe
- Do you have any allergies? If you answered yes, please list using the categories below:

A) Medications _____
B) Latex/rubber products _____
C) Other e.g. hay fever, foods _____

- Have you ever had a peculiar or adverse reaction to any medications or injections? If yes please explain.
  _____ □ Yes □ No □ Not sure/Maybe
- Do you have or have you ever had asthma?
  □ Yes □ No □ Not sure/Maybe
- Do you have or have you ever had any heart or blood pressure problems?
  □ Yes □ No □ Not sure/Maybe
- Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?
  □ Yes □ No □ Not sure/Maybe
- Do you have a prosthetic or artificial joint?
  □ Yes □ No □ Not sure/Maybe
- Have you ever been advised by your doctor to take antibiotics before dental treatment?
  □ Yes □ No □ Not sure/Maybe
- Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
  □ Yes □ No □ Not sure/Maybe
- Have you ever had hepatitis, jaundice or liver disease?
  □ Yes □ No □ Not sure/Maybe
- Do you have a bleeding problem or bleeding disorder?
  □ Yes □ No □ Not sure/Maybe
- Have you ever been hospitalized for any illness or operations? If yes, please explain.
  _____ □Yes □ No □ Not sure/Maybe
- Do you have or have you ever had any of the following? Please check.

□ chest pain, angina	□shortness of breath	□ pacemaker	□ steroid therapy	□ seizures (epilepsy)
□ heart attack	□ prosthetic heart valve	□ lung disease	□ diabetes	□ kidney disease
□ stroke	□ drug/alcohol dependency	□ tuberculosis	□ stomach ulcers	□ thyroid disease
□ cancer	□ arthritis	□ diet pill therapy		

- Are there any conditions or disease not listed above that you have or have had? If so, what?
  _____ □ Yes □ No □ Not sure/Maybe
- Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)
  _____ □ Yes □ No □ Not sure/Maybe
- Do you smoke or chew tobacco products?
  □ Yes □ No □ Not sure/Maybe
- Are you nervous about dental treatment?
  □ Yes □ No □ Not sure/Maybe
- **For women only**: Are you breast-feeding or pregnant? If pregnant, what is the expected date of delivery?
  □ Yes □ No □ Not sure/Maybe
  _____

To the best of my knowledge, the above information is correct:

Patient/Parent Guardian Signature: _____ Date: _____

Dentist Signature : _____ Date: _____

Welcome Smile Office Policies

At Welcome Smile Dental your oral health is our main priority. In order to better serve you, and to ensure there is no interruption in your dental treatment, it is important for all our new patients at the practice to review and understand our office policies as set out below.

FINANCIAL POLICY

Payment of fees must be made at the time services are rendered. For your convenience, we accept cash, Visa, MasterCard, debit & certified cheques. Please note that NSF cheques will be subject to a $25 additional charge to cover administrative and bank charges.

Please be aware that your dental insurance is a contract between you and your employer. It is your responsibility to understand your benefits and dental coverage. However, as a privilege to patients with dental insurance, we will gladly submit your insurance claims electronically to expedite the reimbursement of benefits directly to you from your insurance company. In order to keep your insurance information up-to-date, you must provide our office with all pertinent information relating to your insurance coverage.

Upon request, a written estimate can be provided to you for all treatment planned procedures. If you are uncertain about your dental insurance coverage, our office can send a pre-determination of benefits directly to your insurance company before any services are provided. The pre-determination is non-binding and you are under no obligation to continue with any such treatment.

Should you require special financial arrangements, these must be discussed and arranged in writing in advance of entering into any major treatment. For more involved, complex or extended treatment, a non-refundable deposit may be required prior to the start of your treatment. This deposit will be applied towards your final balance owing.

Please do not hesitate to ask about the estimated cost of your treatment.

It is your right to understand our fees.

CANCELLATIONS & MISSED APPOINTMENTS

When you book an appointment with us, we reserve that time specifically for you to see the dentist or hygienist. As such, we require **48 hours notice** in the event an appointment must be cancelled. This allows other patients awaiting treatment to be rescheduled into the time slot initially reserved for you. Short notice cancellations (i.e. less than 48 hours notice) and missed appointments are subject to a **$100.00 fee per 60 minutes of scheduled time**.

I have reviewed and understand the office policies above, and hereby agree to abide by them.

Print Patient Name:_____ **Patient Signature:**_____

Date: (DD/MM/YY):_____ **Witness Signature:**_____