DYNASTY TOWER DENTAL
HEALTH HISTORY AND REGISTRATION

PERSONAL INFORMATION

Title | First Name | Middle Name | Last Name | Preferred Name

Mr.

DATE OF BIRTH Month Day Year | Address | Unit/Apt. | City | Postal Code

Mobile | Home Phone | Email Address | Marital Status

Single

Occupation | Business Address | Employer | Business Phone

DO YOU HAVE DENTAL INSURANCE? Yes No | INS. COMPANY | G.P.NO/CERT.NO/POLICY NO

Person Responsible For Account | Emergency Contact Person | Emergency Phone

I WAS REFFERED BY: Relative Friend Co-Worker Website Other

Whose name is | If relative, relationship is

MEDICAL HISTORY

It is important that we know about your medical and dental history. These facts a direct bearing on your dental health.
This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Do you have any CURRENT HEALTH problems?	Yes	No	If so,
Are you under a PHYSICIAN'S CARE now?	Yes	No	If so,
Are you PREGNANT?	Yes	No	
Do you SMOKE?	Yes	No	

What MEDICATION are you currently taking?

CHECK ANY OF THE FOLLOWING YOU HAVE HAD, OR PRESENTLY HAVE OR NO TO ALL

Heart Disease or Attack	Heart Surgery	Liver Disease	Chemotherapy (Cancer, Leukemia)	Alergies or Hives
Angina Pectoris	Artificial Joints (Hip, Knee)	Blood Transfusion	Venereal Disease (Syphilis, Gonorrhea)	Diabetes
High Blood Pressure	Anemia	Drug Addiction	Hemophilia	Tyroid Disease
Heart Murmur	Stroke	Osteoporosis	Radiation Treatment	Bruise Easily
Rheumatic Fever	Kidney Trouble	Fever Blisters	Emphysema	Arthritis
Congenital Heart Lesions	Ulcers	Epilepsy or Seizures	Cortisone Medication	Tuberculosis
Mitral Valve Prolapse	A.I.D.S/A.R.C/HIV Pos.	Nervousness	Pain in Jaw Joints	Asthma
Artificial Heart Valve	Hepatitis A (Infectuous)	Psychiatric Treatment	Hay Fever	Alcoholism
Heart Pacemaker	Hepatitis B (Serum)	Glaucoma	Sinus Trouble	Cosmetic Surgery

ARE YOU ALERGIC TO/ORHAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING? NO TO ALL

Aspirin | Nitrous Oxide | Local Anaesthetic | Codeine | Erythromycin | Penicillin | Latex

Are you aware of being allergic to any other medication or substance? Yes No If so, please explain:

Is there any other MEDICAL information that you feel We should know about? Yes No If so, please explain:

FAMILY PHYSICIAN | PHONE

OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we will require 24 HOURS NOTICE. Otherwise it may be necessary to charge for the lost time. SATURDAY AND EVENING APPOINTMENTS REQUIRE 72 HOURS NOTICE. Services are to be paid for at each visit as they are performed. However, in certain circumstances, arrangements for payment may be made by consulting with our business assistant.

PATIENT signature (parent or child)	DATE Month Day Year	DENTIST signature

DENTAL HISTORY

HOW LONG SINCE you have been to a DENTIST?						
Last COMPLETE DENTAL EXAM?	Month		Day		Year	
Last FULL MOUTH X-RAYs?	Month		Day		Year	(16 small films or panoramic)
Are you having any PROBLEMS now?						Yes No
If so, what?						
Do you wear DENTURES?				(Partial or Full)		Yes No
Are you UNHAPPY with your dentures?						Yes No
Would you like to know more about PERMANENT REPLACEMENTS?				(IMPLANT)		Yes No
Are you APPREHENSIVE about dental treatment?						Yes No
Have you had any PERIODONTAL (GUM) treatments?						Yes No
Have you been advised to take ANTIBIOTICS prior to dental treatment / hygiene?						Yes No
Do your gums BLEED, or feel TENDER or IRRITATED?						Yes No
Are your teeth SENSITIVE to hot, cold, sweet, pressure?						Yes No
Are you UNHAPPY with the APPEARANCE of your teeth?						Yes No
Are you aware of GRIDING or CELENCHING your teeth?						Yes No
Do you have HEADACHES, EARACHES or NECK PAIN?						Yes No
Have you worn BRACES on your teeth?				(ORTHODONTICS)		Yes No
Do you have DISCOLOURED teeth that bother you?						Yes No
Would you like your smile to LOOK BETTER or DIFFERENT?						Yes No
Do you REGULARLY use DENTAL FLOSS?						Yes No
Have you had a bad experience or complications during dental treatment?						Yes No

Name of Previous Dentist	City	Province
How do you feel about your teeth?		

Please RANK (1-4) the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # COST of treatment # LACK of concern # MISSING work time #

Note