southview dental

www.southviewdental.com 905.876.4701

PATIENT REGISTRATION

WELCOME TO SOUTHVIEW DENTAL

The information requested in this document is necessary to enable us to provide you with the highest standard of personalized dental care. The protection and privacy of your personal information is important to everyone at Southview Dental and we are committed to collecting, using and disclosing this information responsibly and only as outlined in our Patient Privacy Policy of which you will receive a copy.

Please complete this form, print it and bring it with you to your first appointment.

PERSONAL INFORMATION

Patient Name _____ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

The patient is: an adult ☐ a child ☐ an adult under guardianship ☐ / Date of Birth: _____ Sex: F ☐ M ☐

If the patient is under guardianship: name of guardian: _____ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

Patient Full Address _____

_____ Email Address _____

Patient Home Phone ( ) _____ - _____ Business Phone ( ) _____ - _____ Cell Phone ( ) _____ - _____

How do you prefer to be reached regarding your appointments? Home Phone ☐ Business Phone ☐ Cell Phone ☐ Email ☐

Occupation _____ Employer _____

Who is responsible for this account? _____ Relationship _____

Address (if different from above): _____

Do you have dental insurance? Yes ☐ No ☐ If so, Insurance Co. name: _____

Subscriber ID _____ Policy # _____

Please tell us how you were referred to our office: _____

Family Physician: _____ Phone ( ) _____ - _____

Are you under the care of a Medical Specialist? Yes ☐ No ☐

If yes, name of Specialist _____ Phone ( ) _____ - _____

In case of emergency, who should we contact?

Name _____ Phone ( ) _____ - _____ Relationship _____

HEALTH HISTORY

		Yes	No
1	Are you being, or have you been treated for any medical condition in the past year?	☐	☐
2	Has there been any change in your general health in the past year?	☐	☐
3	When was your last visit to a Physician? _____		
4	Have you recently or are you presently taking any prescription or non-prescription drugs (including herbal remedies)?	☐	☐
5	Have you ever had any adverse or unusual reaction to any medication or injection? (e.g. penicillin or other antibiotics, aspirin, codeine, local anaesthetic / dental freezing)?	☐	☐
6	Have you ever been advised against taking any specific type of medication?	☐	☐
7	Do you have any allergies (e.g. hay fever, food allergies, latex/rubber or metal allergies)?	☐	☐
8	Do you have epilepsy or seizures?	☐	☐
9	Have you ever fainted during dental or medical treatment?	☐	☐
10	Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders?	☐	☐
11	Do you have any artificial joints?	☐	☐
12	Have you ever been advised to take antibiotics before dental treatment?	☐	☐
13	Do you have, or have you ever had, any heart or blood pressure problems (e.g. heart attack or stroke)?	☐	☐
14	Do you have or have you ever had any chest pain, shortness of breath or any heart palpitation without exertion?	☐	☐
15	Are you presently suffering from any infectious diseases?	☐	☐
16	Have you ever had Hepatitis, Jaundice or any liver disease?	☐	☐
17	Do you have any condition that could affect your immune system? (e.g. arthritis, AIDS, HIV infection, Lupus, Inflammatory Bowel Disease, Crohn's Disease)?	☐	☐
18	Indicate which of the following you presently have, or ever had. (Please **X** those that apply) ☐ Asthma ☐ Bronchitis ☐ COPD ☐ Diabetes ☐ Glandular Disorders ☐ Kidney Disease ☐ Lung Disease ☐ Stomach/Intestinal Problems ☐ Thyroid Disease ☐ Tuberculosis ☐ Ulcers		
19	Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer, heart disease)?	☐	☐
20	Do you, or did you smoke?	☐	☐
21	Do you drink alcoholic beverages on a regular basis?	☐	☐
22	Do you use recreational drugs?	☐	☐
23	Is there anything else about your health we should be aware of?	☐	☐
24	Do you wish to speak to the doctor privately about any problem or medical condition?	☐	☐
25	(**Women Only**): Are you taking birth control pills?	☐	☐
26	Are you breast-feeding?	☐	☐
27	Are you or could you be pregnant?	☐	☐
28	If so, your expected delivery date is _____		

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FOR THOSE QUESTIONS TO WHICH YOU ANSWERED "YES" IN YOUR HEALTH HISTORY, PLEASE ELABORATE BY PROVIDING DETAILS AND/OR AN EXPLANATION BELOW.

QUESTION #	DETAILS / EXPLANATION

DENTAL HISTORY

		Yes	No
1	Is there a dental problem you would like treated immediately. If yes, please explain _____	☐	☐
2	Date of your last dental visit was _____ Date of your last dental cleaning was _____		
3	How often do you brush your teeth? _____ Do you feel you have bad breath?	☐	☐
4	Do you use dental floss, proxabrush or stimudents? If so, how often _____	☐	☐
5	Are your teeth sensitive to heat, cold or sweets?	☐	☐
6	Have you ever had: Periodontal treatment (treatment of the gums)?	☐	☐
	Orthodontic treatment	☐	☐
	A Bite Plane or any other dental appliance	☐	☐
	Bite adjustment	☐	☐
	Oral surgery (surgery in or about the mouth/jaw, or implant surgery	☐	☐
7	Do you have any emotional concerns about having dental treatment?	☐	☐
8	Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment?	☐	☐
9	Are you unhappy with the appearance of your teeth? If so, what would you like to see changed? _____		

DENTIST'S NOTES:

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SOUTHVIEW DENTAL FINANCIAL POLICY

You are responsible for the full payment of your appointment fees at the end of each appointment. If you have dental insurance, we can usually assist you in collecting your insurance by electronically filing a dental claim form directly with your insurance company. If your insurance company requires any additional information respecting your claim, we will be pleased to provide that information, as appropriate. After your insurance company has processed your claim, it will reimburse you directly according to your agreement with the insuring company.

In the event that you require a different financial arrangement, one of our administrative staff members will be pleased to discuss your needs prior to your appointment.

APPOINTMENT CANCELLATION POLICY

Your appointment time is set aside specifically for you. We endeavour to keep on schedule in order to be respectful of your time and we request the same courtesy of our patients. If you need to reschedule a booked appointment, please advise us as soon as you become aware. With few exceptions, we require a minimum of 24 hours notice for cancellation.

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal medical and dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical and dental history. Should there be any change in either my health status or any other information I have provided, I will advise this office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the Privacy Policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the Policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine and I assume responsibility for fees associated with these services. I have also read and acknowledge the Appointment Cancellation Policy.

_____ Date _____

Signature: Patient ☐ Parent ☐ Guardian ☐

Reviewed by Treating Dentist: _____ Date _____