

ADVANCED DENTAL ARTS

REGISTRATION FORM

MR. MS.

MRS. MISS LAST NAME: _____ FIRST NAME: _____

BIRTH DATE: ____/____/____ AGE: _____ STREET ADDRESS: _____
MM DD YY

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMAIL ADDRESS: _____

CHOOSE THIS OFFICE/REFERRED TO US BY: DOCTOR FAMILY YELLOW PAGES

FRIEND (NAME: _____) CLOSE TO HOME/WORK

OTHER _____

NAME OF PHYSICIAN: _____ ADDRESS: _____

INSURANCE INFORMATION:

PLEASE INDICATE PRIMARY INSURANCE: _____

SUBSCRIBER'S NAME: _____ BIRTH DATE: ____/____/____
MM DD YY

GROUP #: _____ CONTRACT #: _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER: _____

NAME OF SECONDARY INSURANCE (IF APPLICABLE): _____

SUBSCRIBERS NAME: _____ BIRTH DATE: ____/____/____
MM DD YY

GROUP #: _____ CONTRACT #: _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER: _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DENTISTS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE ADVANCED DENTAL ARTS OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

DATE

PATIENT/GUARDIAN SIGNATURE

ADVANCED DENTAL ARTS

PATIENT DETAIL FORM

OCCUPATION: _____ PLACE OF WORK: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: NAME _____ PH # _____
(DIFFERENT THAN HOME PH #)

ADDRESS: _____

MEDICAL HISTORY:

FAMILY DOCTOR NAME: _____

YES No

ARE YOU CURRENTLY UNDER CARE OF A PHYSICIAN?
IF YES, FOR WHAT? _____

ANY RECENT ILLNESS OR SURGERY?

ARE YOU NOW TAKING DRUGS OR MEDICINE?

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR
HAVE AT PRESENT:

AIDS/HIV	HEART MURMUR
ALLERGIES OR HIVES	HEART PACEMAKER
ANAEMIA	HEART SURGERY
ANGINA PECTORIS	HEPATITIS A (INFECTIOUS)
ARTHRITIS	HEPATITIS B (SERUM)
ARTIFICIAL HEART VALVE	HAEMOPHILIA
ARTIFICIAL JOINT	HIGH BLOOD PRESSURE
ASTHMA	KIDNEY TROUBLE
BLOOD TRANSFUSION	LIVER DISEASE
BRUISE EASILY	NERVOUSNESS
CHEMOTHERAPY (CANCER, LEUKEMIA)	PAIN IN JAW JOINTS
CHRONIC COUGH	PSYCHIATRIC TREATMENT
CONGENITAL HEART LESIONS	RADIATION TREATMENT
COLD SORES	RHEUMATISM
CORTISONE MEDICINE	RHEUMATIC FEVER
DIABETES	SICKLE CELL DISEASE
DRUG ADDICTION	SINUS TROUBLES
EMPHYSEMA	STROKE
EPILEPSY OR SEIZURES	THYROID DISEASE
FAINING OR DIZZY SPELLS	TUBERCULOSIS (TB)
GENITAL HERPES	ULCERS
GLAUCOMA	VENEREAL DISEASE (SYPHILIS, GONORRHOEA)
HAY FEVER	X-RAY OR COBALT TREATMENT
HEART DISEASE OR ATTACK	YELLOW JAUNDICE
HEART FAILURE	

DENTAL HISTORY:

YES No

ARE YOU HAVING DISCOMFORT AT
THIS TIME? EXPLAIN: _____

HOW LONG SINCE YOU HAVE BEEN TO A
DENTIST? _____

WHAT WAS DONE THEN? _____

ARE YOUR TEETH SENSITIVE TO THE
FOLLOWING?

HEAT

COLD

SWEETS

HAVE YOU EVER HAD YOUR TEETH
STRAIGHTENED?

HAVE YOU EVER HAD A GUM
INFECTION?

DO YOU SMOKE?

DO YOU GRIND OR CLENCH YOUR
TEETH? WHEN? _____

WHAT TYPE OF BRUSH DO YOU USE?

ELECTRIC MANUAL

ADDITIONAL CLEANING AIDS? FLOSS

DISCLOSING TABLETS _____

HAVE YOU EXPERIENCED ANY
UNFAVORABLE REACTION FROM ANY
PREVIOUS DENTAL TREATMENT?

ARE YOU SATISFIED WITH THE
APPEARANCE OF YOUR TEETH?

WOMEN ONLY:

ARE YOU PREGNANT OR SUSPECT YOU MAY BE? YES NO

IF YES, WHAT MONTH? _____

ARE YOU TAKING ANY BIRTH CONTROL PILLS? YES NO

DO YOU HAVE ALLERGIES TO COSTUME JEWELRY? YES NO