SHORELINE DENTISTRY

Address : 11 Bronte Rd., Unit 30, Oakville Ontario L6L 0E1

All information is confidential and will remain with this office. The dental administration staff is available to help you complete any portion of this form. Full completion of the forms will allow us to provide you with the highest standard of dental care. Thank you for your co-operation.

REGISTRATION INFORMATION

NAME:_____Dr. / Mr. / Mrs. / Ms. / Miss

Date of Birth:_____ Age:_____

ADDRESS:_____
(Street) (Apt/Unit#) (City) (Prov) (Postal Code)

Home Phone: ( )_____ E-Mail: _____

Bus. Phone: ( )_____ Ext_____ Employer:_____

Cell Number: ( )_____ OHIP#: _____

Whom may we thank for referring you to our practice? _____

How did you hear about us? _____

Do you have a specific need? If yes, please describe: _____

How often do you see the dentist? _____

When was your last dental visit?_____What was done?_____

When was the last time you had any dental x-ray taken?_____

How often do you brush?_____ How often do you Floss?_____

Do your gums ever bleed, are they swollen or painful?_____	YES	NO
Do you ever have jaw joint pain? _____	YES	NO
Do you ever clench or grind your teeth? _____	YES	NO
Do you ever bite your cheek or lip? _____	YES	NO
Are you aware of any swelling, sore spots or lump(s) in your mouth? _____	YES	NO
Have you ever had any traumatic injury to your face? _____	YES	NO
Have you ever noticed any loose teeth or have any of your teeth shifted?_____	YES	NO
Does food catch between your teeth? _____	YES	NO
Have you been advised to take antibiotics before a dental appointment? _____	YES	NO
Do you smoke? If so, how much? _____	YES	NO
Are you wearing the transdermal nicotine patch? _____	YES	NO

Do you drink? If so, how much? _____ _____. YES NO

Do any of your teeth hurt/ache (e.g. sensitive to sweet, cold, hot, pressure)?_____ YES NO

Please describe: _____

Have you had any kind of oral surgery? _____ YES NO

Doctor who performed oral surgery:_____ Phone ( )_____

Have you ever had Orthodontics (Braces)?_____ YES NO

Doctor's Name:_____ Phone ( )_____ Date of last exam: _____

Do you have or have had any of the following? Please indicate by circling:

heart problems / surgery
pacemaker
chest pain
excessive bleeding
fainting / dizziness
blood disorders
high / low blood pressure
anemia
sinus problems
asthma / emphysema
lung / breathing problems
surgery in hospital
organ transplant /medical implant

diabetes
kidney problems
hepatitis / liver problems
rheumatic / scarlet fever
epilepsy / seizures
measles / mumps / chicken pox
thyroid disease
ulcers / stomach problems
stroke / paralysis
arthritis / gout
circulation problems artificial joints (e.g. hip, knee)
pregnancy (months?____)

strep throat
tonsillitis
tuberculosis
transmittable diseases
venereal disease, herpes
HIV / AIDS
contagious diseases
anxiety problems
psychiatric problems
steroid therapy
cancer / tumors
radiation or chemotherapy

Allergies:_____

Please indicate any other medical conditions that we have not mentioned above: _____

_____

Please indicate any PRESCRIPTION or NON-PRESCRIPTION medications, pills or drugs which you are taking: _____
Do you have FREQUENT, SEVERE headaches, earaches, ear/throat infections?_____

Do you have any other questions or concerns?_____

Any other family members patients at our office?(please list)_____

Do you have Dental Insurance?_____ Name of policy holder?:_____

Employer of individual subscriber:_____ Date of Birth of policy holder: _____
M/ D/ Y

Name of insurance Company:_____

Group/Policy #_____ Certificate/ID#_____

Is there Secondary/Co- insurance? If yes, Name of policy holder?:_____

Employer of individual subscriber:_____ Date of Birth of policy holder: _____
M/ D/ Y

Name of insurance Company:_____

Group/Policy #_____ Certificate/ID#_____

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-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 - dental history. **Should there be any change in my health status in the future, I will advise this dental 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 healthcare provider may be necessary, and I consent to the release of this information. I authorize release, to my insurance company/plan administrator, the information contained in claims electronically and for direct assignment to the dental office, if applicable. 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.

Please Note: A potential fee of $50 may be charged for any missed/rescheduled appointments without 2 full business day's notification.

X_____
(Signature) Patient ___ Parent___ Guardian___ (print name of guardian)

Date:_____ Reviewed by Treating Dentist: _____