



OrbDental

DR. RAVEENDRAN

102-3025 Hurontario St. Mississauga ON

Patient Registration Form

The personal information provided below will be protected and kept private by our office. All information will be used and disclosed responsibly according to the Privacy Act standards set up and monitored by our office.

Mr. Mrs. Miss. Ms. Dr. Male Female Adult Child Marital Status: _____

Name: Last _____ Middle _____ First _____ Prefer to be called _____

Address: Street _____ Apt. # _____ City _____ Postal Code _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ X _____ Date of Birth: ____/____/____
MM DD YY

Email: _____ Cell: (____) _____ - _____ Best Way to Reach: _____

Employer / School: _____ Occupation: Name _____

Referral Source TV Radio Newspaper Flyer Mail Person: _____

Are you likely to be available on short notice for future appointments? Yes No

Family Physician: _____ Phone: (____) _____ - _____ X _____

In Case of emergency Notify: _____ Relation: _____ Phone: (____) _____ - _____ X _____

Person responsible for this account: Self Spouse Parent Legal Guardian Other: _____

Name: Last _____ First _____ Initial _____ Relation: _____

Address: Street _____ Apt. # _____ City _____ Postal Code _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ X _____

Primary Insurance	Secondary Insurance
Subscriber: _____ Date of Birth: _____	Subscriber: _____ Date of Birth: _____
Relation: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	Relation: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____
Subscriber I.D.: _____ SIN: _____	Subscriber I.D.: _____ SIN: _____
Insurance Co: _____	Insurance Co: _____
Policy/Plan #: _____ Division/Sect. #: _____	Policy/Plan #: _____ Division/Sect. #: _____
Are You Familiar with Your Plan Details? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are You Familiar with Your Plan Details? <input type="checkbox"/> Yes <input type="checkbox"/> No
Method of Payment: <input type="checkbox"/> Cash <input type="checkbox"/> Cheque <input type="checkbox"/> Credit Card: _____ Number: _____ Exp.: _____	

DENTAL HISTORY

1. When was your last dental visit?	_____	_____	_____
2. When did you last have dental X-rays?	_____	_____	_____
3. How often do you brush your teeth?	_____	_____	_____
4. How often do you floss your teeth?	_____	_____	_____
5. Have you been seeing a dentist regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do any of your teeth ache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been advised to take antibiotics before dental appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have any pain when you chew?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you feel that you have bad breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been in a vehicle accident or experienced blows to your jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you being followed-up by a dental specialist?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have any jaw joint problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had: Braces <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Gum Treatment <input type="checkbox"/> Root Canal <input type="checkbox"/> Dental Implant <input type="checkbox"/>			

REGISTRATION

DENTAL, MEDICAL HISTORY

MEDICAL HISTORY

In order to provide safe dental care for our patients, we are asking you to fill out the following questionnaire. Please answer the questions as accurately as you can.

	YES	NO	NOT SURE
1. Are you being treated for any medical condition at the present or have you been treated within the last year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. When was your last medical check-up? (Reason for the visit)			
3. Has there been any change in your general health in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you taking any medications or non-prescription drugs of any kind? If the answer is "YES", please list them below,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies? If "YES", list using the categories below,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a) Medications			
b) Latex / Rubber Products			
c) Other (Hayfever / Food)			
6. Have you ever had a peculiar or adverse reaction to any medicines or injections? e.g. Penicillin, aspirin or local anesthetics (dental freezing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have or ever had jaundice, hepatitis or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been told that you should not give blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have any conditions that could affect your immune system? e.g. AIDS, HIV positive, Leukemia, radiotherapy, chemotherapy etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have a tendency to bruise easily or bleed for a prolonged period after being cut?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been hospitalized for any serious illness or operations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have a prosthetic or artificial joint?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had any of the following? Please check only those that apply.			
<input type="checkbox"/> Chest pain/Angina <input type="checkbox"/> Bronchitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Blood Pressure			
<input type="checkbox"/> Heart Attack <input type="checkbox"/> Asthma <input type="checkbox"/> Stomach Ulcer <input type="checkbox"/> Arthritis <input type="checkbox"/> Pace maker			
<input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Drug/Alcohol Dependency <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Prosthetic Heart Valve			
<input type="checkbox"/> Lung Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Disease			
<input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Cancer <input type="checkbox"/> Steroid Therapy <input type="checkbox"/> Osteoporosis Medications			
<input type="checkbox"/> Heart Murmur/Mitral Valve Prolapses			
14. Are there any conditions or diseases not listed above you have or have had? If you answered 'YES' please list them:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you smoke or chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. For women only, are you pregnant/breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, when is the expected date of delivery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To the best of my knowledge, the above information is correct and acknowledge the fact that I am financially responsible for all treatment. I also consent to necessary Dental treatment according to treatment plan, explained by the Dentist.

Patient's / Guardian's Signature: _____ Date: _____

Reviewed by treating Dentist: _____ Date: _____