OrbDental

DR.RAVEENDRAN

1139 Morningside Ave, suite 25 Scarborough, 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 Sourse ☐ 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

Subscriber: ________ Date of Birth: ________

Relation: ☐ Self ☐ Spouse ☐ Other: ________

Subscriber I.D.: ________ SIN: ________

Insurance Co: ________

Policy/Plan #: ________ Division/Sect. #: ________

Are You Familiar with Your Plan Details? ☐ Yes ☐ No

Secondary Insurance

Subscriber: ________ Date of Birth: ________

Relation: ☐ Self ☐ Spouse ☐ Other: ________

Subscriber I.D.: ________ SIN: ________

Insurance Co: ________

Policy/Plan #: ________ Division/Sect. #: ________

Are You Familiar with Your Plan Details? ☐ Yes ☐ No

Method of Payment: ☐ Cash ☐ Cheque ☐ 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? ________

Question	YES	NO	NOT SURE
5. Have you been seeing a dentist regularly?	☐	☐	☐
6. Do any of your teeth ache?	☐	☐	☐
7. Have you ever been advised to take antibiotics before dental appointments?	☐	☐	☐
8. Do your gums bleed when you brush?	☐	☐	☐
9. Do you have any pain when you chew?	☐	☐	☐
10. Do you feel that you have bad breath?	☐	☐	☐
11. Have you ever been in a vehicle accident or experienced blows to your jaw?	☐	☐	☐
12. Are you being followed-up by a dental specialist?	☐	☐	☐
13. Do you have any jaw joint problems?	☐	☐	☐

14. Have you ever had: Braces ☐ Oral Surgery ☐ Gum Treatment ☐ Root Canal ☐ Dental Implant ☐

____

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?	☐	☐	☐
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?	☐	☐	☐
4. Are you taking any medications or non-prescription drugs of any kind?	☐	☐	☐
If the answer is "YES", please list them below,			
5. Do you have any allergies? If "YES", list using the categories below,	☐	☐	☐
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)	☐	☐	☐
7. Do you have or ever had jaundice, hepatitis or liver disease?	☐	☐	☐
8. Have you ever been told that you should not give blood?	☐	☐	☐
9. Do you have any conditions that could affect your immune system? e.g. AIDS, HIV positive, Leukemia, radiotherapy, chemotherapy etc.	☐	☐	☐
10. Do you have a tendency to bruise easily or bleed for a prolonged period after being cut?	☐	☐	☐
11. Have you ever been hospitalized for any serious illness or operations?	☐	☐	☐
12. Do you have a prosthetic or artificial joint?	☐	☐	☐

13. Have you ever had any of the following? Please check only those that apply.

☐ Chest pain/Angina	☐ Bronchitis	☐ Tuberculosis	☐ Kidney Disease	☐ Blood Pressure
☐ Heart Attack	☐ Asthma	☐ Stomach Ulcer	☐ Arthritis	☐ Pace maker
☐ Epilepsy/Seizures	☐ Drug/Alcohol Dependency		☐ Shortness of breath	☐ Prosthetic Heart Valve
☐ Lung Disease	☐ Diabetes	☐ Stroke	☐ Thyroid Disease	
☐ Rheumatic Fever	☐ Cancer	☐ Steroid Therapy	☐ Osteoporosis Medications	
☐ Heart Murmur/Mitral Valve Prolapses				

	YES	NO	NOT SURE
14. Are there any conditions or diseases not listed above you have or have had?	☐	☐	☐
If you answered 'YES' please list them:			
15. Do you smoke or chew tobacco?	☐	☐	☐
16. For women only, are you pregnant/breastfeeding?	☐	☐	☐
If so, when is the expected date of delivery?	☐	☐	☐

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: ____________________