SMILE CARE
DENTAL CENTER

32465 S Fraser Way #3
Abbotsford, British Columbia
T. **604-744-2262** E. **info@abbysmilecare.com**

Date: ____________
mm / dd / yyyy

PATIENT REGISTRATION

WELCOME TO OUR OFFICE

The following information is required by the dentist to assist in proper diagnosis and treatment. It is important to have complete answers. The information is **STRICTLY CONFIDENTIAL**. Please feel free to ask the receptionist for help in completing this form.
PLEASE PRINT.

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Name: ______________________ (Last) ______________________ (First) __________ (Inital) Date of Birth: ____________ (mm / dd / yyyy)

Address: ______________________ (Street) ______________________ (City) __________ (Province) __________ (Postal Code)

Home Phone: ______________ Cell: ______________ Email: ______________________

Occupation: ______________ Employer: ______________________ Phone: ______________

Family Physician: ______________________________ Phone: ______________

Best Contact Method: ☐ Text ☐ Cell ☐ Email ☐ Home

In case of emergency, please notify: ______________ Relationship: ______________ Phone: ______________

How did you hear about our office? ______________________________

MEDICAL HISTORY

1. Have you ever had a serious illness or are you under the care of a physician now? ☐ YES ☐ NO
   Specify: ______________________________
2. Are you taking any prescription or non-prescription medication? ☐ YES ☐ NO
   Specify: ______________________________

3: Have you ever experienced any unusual reaction from any of the following:

☐ Local Anesthesia	☐ Aspirin	☐ Penicillin	☐ Codeine
☐ Sulfonamide (sulfa)	☐ Barbiturates (sleeping pills)	☐ Iodine	☐ Other: ______________

4. Do you have any allergic condition? i.e. asthma, hay fever, rash, food allergies ☐ YES ☐ NO
5. Have you been warned against taking any drug or medication? ☐ YES ☐ NO
6. Do you have or have you ever had any of the following:

☐ Heart Murmur	☐ Other Heart Condition	☐ Joint/Valve Replacement
☐ Stomach/Intestinal Problems	☐ Mental/Nervous Disorder	☐ High/Low Blood Pressure
☐ Hyper/Hypo Glycemia	☐ Epilepsy or Seizures	☐ Hepatitis
☐ Jaundice	☐ Diabetes	☐ Tuberculosis
☐ Lung Disease	☐ Venereal Disease	☐ Thyroid Disease
☐ Stroke	☐ Arthritis or Rheumatism	☐ Scarlet or Rheumatic Fever
☐ Kidney Disease	☐ Cancer	☐ Liver Disease
☐ Sinus Trouble	☐ Herpes	☐ Cold Sores
☐ Hemophilia	☐ Covid-19	☐ Other: ______________

7. Have you had any indication of HIV infection, AIDS, or any other disorder of the immune system? ☐ YES ☐ NO
8. Do you have any blood disorders? i.e. anemia or thalassaemia ☐ YES ☐ NO
9. Do you bruise easily or bleed abnormally? ☐ YES ☐ NO
10. Do you have a tendency to faint? ☐ YES ☐ NO
11. Do you have frequent severe headaches? ☐ YES ☐ NO
12. Have you ever had any injury, surgery or radiation therapy to you face or jaws? ☐ YES ☐ NO
13. Do you have frequent earaches, ear/throat infections or hearing difficulties? ☐ YES ☐ NO
14. Do you ever experience shortness of breath or pain in your chest? ☐ YES ☐ NO
15. Have you any organ transplants or medical implants? ☐ YES ☐ NO

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16. **WOMEN ONLY** - Are you pregnant? ☐ YES ☐ NO
    If so, what is your due date? ____________ Are you taking birth control? ☐ YES ☐ NO
17. Do you have any disease, condition or problem not listed above that you think the doctor should know about? ☐ YES ☐ NO
    Specify: ____

IN ORDER TO AVOID COMPLICATIONS AS A RESULT OF A CHANGE IN YOUR MEDICAL CONDITION, IT IS IMPORTANT THAT YOU NOTIFY OUR OFFICE OF THESE CHANGES.

DENTAL HISTORY

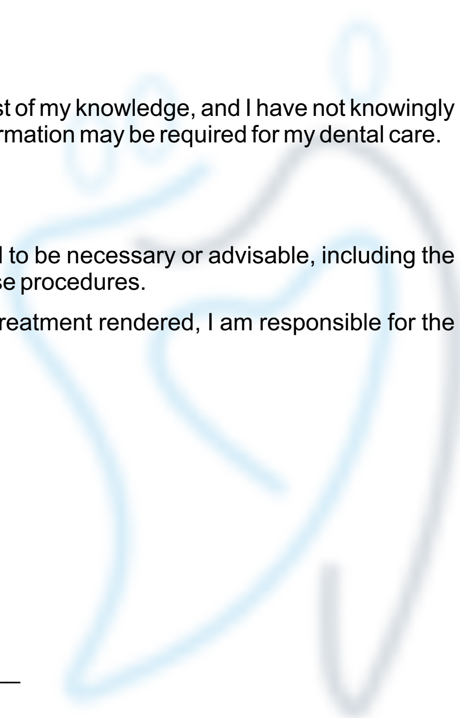
1. Is there a problem you would like to take care of as soon as possible? ____
   ____
2. How frequently do you see a dentist? ______________________ Former Dentist: ________________________________
3. When was your last dental visit? ____________ What was done? ____
4. How often do you brush your teeth? ____________ Floss your teeth? ____
5. Cleaning aids presently used? ☐ Electric Brush ☐ Toothpick ☐ Stimudent ☐ Other
6. Are any of your teeth sensitive to: ☐ Cold ☐ Heat ☐ Sweets ☐ Biting
7. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Spontaneously
8. Does any part of your mouth hurt when clenched? ☐ YES ☐ NO
9. Does your jaw crack or pop when opened widely? ☐ YES ☐ NO
10. Have you experienced any growth or sore spots in your mouth? ☐ YES ☐ NO
    If so, where? ____________________________________
11. Habits: Do you
    - grind or clench your teeth? ☐ YES ☐ NO
    - mouth breathe while awake or sleeping? ☐ YES ☐ NO
    - bite your lips or cheeks regularly? ☐ YES ☐ NO
    - bite on foreign objects? (pencil, fingernails) ☐ YES ☐ NO
    - smoke? ☐ YES ☐ NO
    ☐ Cigarettes ☐ Cigars ☐ Pipe How Much? _____________
12. Are you interested in any of the following:
    ☐ Orthodontics (braces) ☐ Repairing Chipped Teeth ☐ Improved Gum Health
    ☐ Bonding (cosmetic) ☐ Bleaching (whitening teeth) ☐ Improving Your Bite
    ☐ Closing Spaces Between Teeth ☐ Crowns (caps) ☐ Sports Mouth Guard
    ☐ Replacing Missing Teeth ☐ Improved Breath Odor ☐ Improving Your Smile
13. Do you have any concerns regarding your dental visit? ☐ YES ☐ NO
    ☐ Fear ☐ Pain ☐ Time ☐ Money ☐ Other: ________________________

☐ I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary, as this information may be required for my dental care.

CONSENT FOR TREATMENT

☐ I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and will assume responsibility for fees associated with these procedures.

☐ I am aware that if for any reason the insurance company does not pay the full amount for the treatment rendered, I am responsible for the balance.



____
Patient (Parent, Guardian) Signature:

____ ____________________
If Parent, Guardian, please print name: Date (mm/dd/yyyy)

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