CAMBRIDGE SMILES FAMILY DENTISTRY
PATIENT REGISTRATION

Last Name: _____ First Name _____

Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

Marital Status: M S D W Date of Birth: ____/____/_____ Age:_____
M D YYYY

Employer: _____ Occupation: _____

Health Card #: _____ Name of Family Doctor: _____

Cell Phone: _____ Work Phone:_____ ext _____

Home Phone_____ E-mail Address_____

Please Note: if you are providing a CELL # OR EMAIL ADDRESS you will be contacted by an automatic text/email reminder confirmation system. If you choose not to have this in place, please advise us.

Who should we call in case of an Emergency: Name_____

Phone Number: _____ Relationship to Patient: _____

How did you hear about our office? Road Sign / Google / Staff Member / Patient Referral / Facebook
Live in the Area / Website / Family or Friend / Other

Please list all other members of your immediate family who are patients in our office:

_____

DENTAL INSURANCE INFORMATION

Primary Insurance Company: _____ Plan Holder Name: _____

Plan Number: _____ Certificate/ID Number: _____

Secondary Insurance Company: _____ Plan Holder Name: _____

Plan Number: _____ Certificate/ID Number: _____

PARENT/GUARDIAN (if a minor) or SPOUSE INFORMATION

Parent/Spouse Name: _____ Date of Birth: _____/_____/_____
D M YYYY

MEDICAL INFORMATION

Please circle any of the following which you have had or have currently:

Alcohol or Drug abuse	Diabetes	Latex Allergy
Anemia or Hemophilia	Epilepsy or Seizures	Liver Disease
Arthritis	Fainting or Dizzy spells	+ HIV or Aids
Artificial Heart Valve/Joints	Heart Murmur	Radiation Therapy
Asthma	Heart Problems	Respiratory Disease
Cancer or Tumor	Hepatitis	Rheumatic Fever
Chemotherapy	High Blood Pressure	Sinus Problems
Cold Sores	Kidney Disease	Thyroid Disease

Other Medical Conditions (not listed above):_____

_____

Have you been under the care of a medical doctor during the past two years? YES NO

If yes, for what reason? _____

Medical Doctor's Name and Phone Number: _____

Have you ever been told you need to be pre-medicated prior to dental work? YES NO

Are you currently taking any natural supplements, prescription or over-the-counter drugs? YES NO

If yes, list supplement/drug and dosage:

_____

_____

_____

What medications are you allergic to?_____

Any other knows allergies? _____

Tobacco Use: Do you currently use a form of tobacco? YES NO How much per day? _____

Marijuana Use: Are you currently using marijuana either as medical or recreational? YES NO

Women Only: Are you, or do you think you may be pregnant? YES NO

Due Date:_____ Are you currently nursing an infant? YES NO

Date:_____ Signature of patient or legal guardian:_____

DENTAL HISTORY INFORMATION

Tell us your story…..Cambridge Smiles Family Dentistry strives to provide optimal oral health to our patients.
Please complete the dental survey to the best of your knowledge to help us get to know you and your oral health!

When was your last dental visit? _____

What was the reason for leaving previous office? _____

Are you having any dental problems currently? YES NO Do your gums bleed when you brush? YES NO

Do your gums bleed when you floss? YES NO Are you nervous to have dental treatment? YES NO

Have you had a bad dental experience at a dental office before? YES NO

What would you change about your smile?

Replacing missing teeth YES NO

Appearance of Smile YES NO

Straighter Teeth YES NO

Whiter Teeth YES NO

Gum Disease YES NO

Bad Breath YES NO

Other: _____

The information above is accurate and completed to be the best of my knowledge. I agree to inform the team of CAMBRIDGE SMILES, of any changes in my medical condition.
I also agree that no employee at CAMBRIDGE SMILES shall be held responsible for any error or omission that I may have made in the completion of my medical and dental information.

Sign:_____ Date: _____