FORT MALDEN DENTISTRY
DR. SLIPCHUK & ASSOCIATES

*Date month/day/year ______/______/_______*

*In order to provide you with the highest standard of dental care, please provide our dental office with the following Personal Information and Medical and Dental Histories. The protection and privacy of your personal information is important to our office and we are committed to collecting, using, disclosing this information responsibly.* ***Please complete this form by neatly printing.***

## ADULT PATIENT REGISTRATION INFORMATION

| Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms ☐ Other:___________ | | |
|---|---|---|
| Name: (Last, First, Ini) | | Date of Birth: |
| Address: | Town/City: | Postal Code: |
| Home Phone: | Mobile: | Email |

*In the future, please circle how we may contact you to confirm your appointments: Email or Telephone ( home or mobile )*

| | |
|---|---|
| *Employer Name:* | *Employer Phone Number:* |
| *Family Physician Name:* | *Physician Phone Number:* |
| *Your Spouse's Name:* | |
| *Your Spouse's Employer:* | *Spouse's Employer Phone Number:* |
| *Emergency Contact Name:* | *Phone:* |
| *Is another family member a patient here at our office?* Yes ☐ or No ☐ | *If yes, Name:* |

## CHILD PATIENT REGISTRATION INFORMATION

| | |
|---|---|
| Name: (Last, First, Ini) | Date of Birth: |
| Address: (if different from above) | |
| Home Phone: (if different from above) | Mobile: (if different from above) |
| School: | Grade |
| Emergency Contact Name: | Phone: |
| *Is another family member a patient here at our office?* Yes ☐ or No ☐ | If yes, Name: |

**MEDICATIONS:** ***LIST ALL PRESCRIPTION, NON-PRESCRIPTION, HERBAL MEDICATIONS THAT YOU ARE TAKING-- INCLUDE NAME, DOSE AND FREQUENCY. (**IF THE LIST IS LENGTHY PLEASE GIVE LIST TO RECEPTIONIST TO PHOTO COPY**)***

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| Pharmacy Name: | Pharmacy Phone Number | |

| **INSURANCE INFORMATION** | ***Single Coverage*** | | ***Double Coverage*** |
|---|---|---|---|
| Name of Insured & Birthday | | Name of Insured & Birthday | |
| Primary Insurance Carrier | | Secondary Insurance Carrier | |
| Group/Policy Number | | Secondary Group/Policy Number | |
| I.D. Number | | Secondary I.D. Number | |
| Division Number | | Secondary Division Number | |

## MEDICAL INFORMATION (circle one)

| | | |
|---|---|---|
| Have you ever had extensive medical care? Yes ☐ or No ☐ | *Describe* | |
| Are you presently under the care of a physician? Yes ☐ or No ☐ | *Describe* | |
| Have you been hospitalized in the last 5 years? Yes ☐ or No ☐ | *Describe* | |
| Have you had a medical examination in the last year? Yes ☐ or No ☐ | Date: | Type: |
| **Do you have any allergies to any medication?** Yes ☐ or No ☐ | If yes, please describe: | |
| **Do you have any allergic conditions?** (i.e. latex, metal, food allergies) ? Yes ☐ or No ☐ | | |
| Have you ever been advised **not to take** a certain drug or medication? Yes ☐ or No ☐ | Describe | |
| Has your Doctor ever told you **to take antibiotics** prior to a dental procedure? Yes ☐ or No ☐ | If yes, when? | |

**Please circle if you have a history of any of the following:**

| | | | |
|---|---|---|---|
| Heart Murmur or Mitral Valve Prolapse | Malignant Hyperthermia | Hepatitis A/B/C | Liver Disease/Jaundice |
| Stomach/intestinal problems | Positive Testing for HIV/AIDS | Joint Replacement (hip, knee, etc.) | Venereal Disease |
| Heart Attack/Stroke | Herpes | Mental or Nervous Disorders | Lung Disease |
| Cortisone/Steroid Therapy | Cold Sore | Sinus Trouble | High Blood Pressure |
| Thyroid Disease | Diabetes | Cancer | Low Blood Pressure |
| Arthritis or Rheumatism | Tuberculosis | Kidney Disease | Epilepsy or Seizures |
| Hypoglycemia/Hyperglycemia | Scarlet/Rheumatic Fever | Drug/Alcohol Addiction | Bleeding Disorders |

Other ___________________________

**Do you have any disease, condition or problem that you think the doctor should know about? Y N**

If yes, describe___________________________________________________________________________________________

| **Please circle either Yes or No to each question:** | | |
|---|---|---|
| Have you ever had any known contact with the AIDS virus? | Y N | *Describe* |
| Has any member of your family had diabetes? | Y N | *Describe* |
| Do your ankles swell during the day? | Y N | *Describe* |
| Have you had any weight changes lately? | Y N | *Describe* |
| Do you have any blood disorders such as anemia (thin blood, thalassemia) | Y N | *Describe* |
| Have you ever had radiation treatment or chemotherapy? | Y N | *Describe* |
| Have you ever had an injury, surgery or x-ray therapy to your face or jaw? | Y N | *Describe* |
| Do you have frequent earaches, ear/throat infections or hearing difficulties? | Y N | *Describe* |
| Is your eyesight: Good Adequate Poor<br>Do you wear contact lenses? | Y N | *Describe* |
| Are you on a special diet? | Y N | *Describe* |
| Have you ever fainted? | Y N | *Describe* |
| Do you ever experience shortness of breath or chest pain when walking or climbing stairs? | Y N | *Describe* |
| Have you had any organ transplants or medical implants? | Y N | *Describe* |
| Do you have any disease, condition or problem that you think the doctor should know about? | Y N | *Describe* |
| Is there anything about yourself that we should be made aware of? | Y N | *Describe* |
| Have you ever been diagnosed or treated for Osteoporosis or Osteopenia? | Y N | *Describe* |
| Have you ever taken any of these medications | | |

| | | | |
|---|---|---|---|
| Etdronate (Didronel) | Y N | Ibandronate (Boniva) | Y N |
| Tiludronate (Skelid) | Y N | Pamidronate (Aredia) | Y N |
| Alendronate (Fosamax) | Y N | Zoledronate (Zometa) | Y N |
| Risedronate (Actonel) | Y N | | |

| | | |
|---|---|---|
| Have you ever received chemotherapy treatment (IV or oral)? | Y N | *Describe* |

**FEMALE PATIENT INFORMATION (Adult)**

| | | | | |
|---|---|---|---|---|
| Are you pregnant? | Y N | If yes, which month are you in? | | Name of Obstetrician |
| Are you Taking Birth Control Pills | Y N | *If yes, Describe* | | |
| Have you ever been diagnosed or treated for multiple myeloma or breast cancer? | Y N | *Describe* | | |

If you answered Yes to any of the above questions, please provide the following information:

Name and phone number of your Primary Physician ____________________________ Phone ________________________________
Name and phone number of your Specialist ____________________________ Phone ________________________________

## MALE PATIENT INFORMATION (Adult)

| Have you ever been diagnosed or treated for multiple myeloma or prostate cancer? | Y N | Describe |
|---|---|---|

If you answered Yes to any of the above questions, please provide the following information:
Name and phone number of your Primary Physician ____________________________ Phone ________________________________
Name and phone number of your Specialist ____________________________ Phone ________________________________

## DENTAL HISTORY

| | | | | | | |
|---|---|---|---|---|---|---|
| Is there a dental problem you would like to have taken care of as soon as possible? | Y N | Describe | | | | |
| How frequently do you see your dentist (circle one) | 3 months | 6 months | Yearly | Other | | |
| Name of former dentist | | Last dental visit | | | | |
| Have you been given oral hygiene instruction in brushing? | Y N | Flossing? | Y N | | | |
| Brushing (circle one) | Vigorous | Light | How often? | Type of brush | | |
| How often do you floss? | | | | | | |
| Other cleaning aids used: | Stimudents | Y N | Toothpick | Y N | Other | |
| Are any of your teeth sensitive to: | Cold | Y N | Sweets | Y N | Other | |
| Do your gums bleed when: | Brushing | Y N | Flossing | Y N | Spontaneous | Y N |

Have you ever had or do you now have any of the following? (please circle)

- Bridges
- Partial Denture
- Gag easily
- Root Canals
- Gum Treatments
- Lost Fillings
- Extractions
- Full Dentures
- Orthodontic Treatment
- Difficulty opening or closing jaw
- Bite Appliance/Night Guard
- Swelling or pain in your mouth or jaws
- Loose Teeth
- Injury to face or jaw

| | | | | | | |
|---|---|---|---|---|---|---|
| Do you chew on only one side of your mouth? | Y N | *Describe* | | | | |
| Does any part of your mouth hurt when clenched? | Y N | *Describe* | | | | |
| Does your jaw crack or pop when opened widely? | Y N | *Describe* | | | | |
| Do you have any pain in your ears? | Y N | *Describe* | | | | |
| Have you experienced any growths or sore spots in your mouth? | Y N | *Describe* | | | | |
| Do you grind or clench your teeth during the night or day? | Y N | *Describe* | | | | |
| Do you mouth breathe while awake or asleep? | Y N | *Describe* | | | | |
| Do you bite your lips or cheeks regularly? | Y N | *Describe* | | | | |
| Do you hold any foreign objects with your teeth? (pipe, pencils, nails) | Y N | *Describe* | | | | |
| Do you smoke? | Y N | (circle if yes) | cigarettes | cigars | pipe | other | No. Per day _______ |

**Circle any of the following that you are interested in:**

| | | | |
|---|---|---|---|
| Orthodontics | Repairing chipped teeth | Improved gum health | Bonding |
| Bleaching | Improving your bite | Closing spaces | Crowns |
| Improving breath odour | Replacing missing teeth | Sport mouth guard | Improving your smile |

**How did you find out about our office? (circle one)**

Referred by: _______________________ Drive By Welcome Wagon Phone Book Advertisement Website

*****We would greatly appreciate a notice of at least 2 full business days if you need to make changes to your appointments.*****