PATIENT REGISTRATION INFORMATION

Date:_____

The data on this confidential questionnaire is essential in our efforts to provide you with the best professional care. We appreciate your co-operation in completing it. Our office is in compliance with the ***National Personal Information Protection and Electronic Document Act***. Thank you.

Mr./Mrs./Ms./Dr._____ Date of Birth: D_____M_____Y_____
Last Name *First Name*

Phone Home: _____ Bus: _____Cell Phone: _____

Home Address:_____Apt: _____City_____ Postal Code: _____

Email address:_____Driver's License or OHIP No.:_____

Referring Dentist:_____ Phone:_____

Family Dentist: _____ Phone_____

Family Physician:_____ Phone: _____

Do you have dental insurance coverage? Yes/ No

Insurance Company:_____

Policy Holder: _____ DOB:_____

Policy/Group #:_____Certificate ID#: _____

Medical Information:

	Yes	No	Don't know
1. Do you have inflamed areas or sore spots in or around your mouth?			
2. Has there been any change in your general health within the past year?			
3. Are you under the care of a physician for a current problem?			
4. Have you been hospitalized within the past 5 years? Please specify.			
5. Have you received therapy for alcoholism or drug addiction during the past 5 years?			
6. Have you ever had any ALLERGIC or BAD REACTIONS to anesthetics/antibiotics/ medications?			
7. Have you had abnormal bleeding with previous extractions, surgery, or trauma?			
8. Have you ever required a blood transfusion?			
9. Have you ever had radiation for any condition?			
10. Have you ever tested positively for HIV infection or AIDS? If so, state date diagnosed and treating doctor.			
11. Have you ever been told by your medical doctor that you require a single dose of antibiotics before every dental appointment?			
12. Are you taking any bisphosphonates now or have taken them in the past (Fosamax)?			
13. Are you taking any medication or drugs? Please list them below or provide separate sheet.			

14. Do you have or have you had any of the following?

- ☐ High blood pressure
- ☐ Heart murmur or prolapsed valve
- ☐ Joint prosthesis (hip, knee, etc.)
- ☐ Rheumatic fever or heart disease
- ☐ Congenital heart disease
- ☐ Heart attack, stroke or bypass
- ☐ Prosthetic heart valve
- ☐ Blood disorder (e.g. anemia)
- ☐ Venereal disease
- ☐ Asthma
- ☐ Allergy to latex
- ☐ Low blood pressure
- ☐ Chest pain, angina
- ☐ Swollen ankles, arthritis or joint disease
- ☐ Cardiac pacemaker
- ☐ Heart surgery
- ☐ Delay in healing
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ X-Ray treatment or chemotherapy
- ☐ On a diet
- ☐ History of alcohol abuse
- ☐ Eye disease or glaucoma
- ☐ Infectious mononucleosis
- ☐ Sinus trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach ulcers, colitis
- ☐ Hepatitis, jaundice, liver disease
- ☐ Psychiatric treatment
- ☐ Fainting spells or seizures
- ☐ Epilepsy
- ☐ Cancer
- ☐ Temporomandibular joint problems (TMJ)
- ☐ Low blood sugar
- ☐ Dialysis
- ☐ Irregular heart beat
- ☐ Contagious diseases
- ☐ Bronchitis, chronic cough
- ☐ Hay fever or sinus problems
- ☐ Problems with the immune system
- ☐ Difficult breathing or other lung trouble
- ☐ Chronic fatigue or night sweats
- ☐ History of drug abuse
- ☐ Wear contact lenses
- ☐ Bruise easily
- ☐ Gallbladder trouble
- ☐ **None of the above**

Women only:	Possibility of pregnancy: YES / NO	Nursing: YES / NO
Estimated delivery date:		Taking birth control pills: YES / NO

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of control.

A thorough examination and consultation is a crucial and necessary service prior to the initiation of endodontic treatment. A fee is assessed for based on the Ontario Dental Association fee guide for certified specialists. Payment of this fee is expected at this examination appointment.

I acknowledge full responsibility for the payment of such services for my endodontic treatment and agree to pay for them in full when the services have been rendered, unless other specific arrangements are made with the secretary.

I also understand that it will be necessary for me to return to my family dentist for the permanent restoration following the root canal procedure.

Uptown Endodontics may communicate with me and/or my dental specialist, via email utilizing their secured, non-encrypted email server. I acknowledge that the practice may send the following electronic communications:

- Information about my invoice or accounts payable upon request, to patient/guardian
- Information about a specific dental visit.
- Information, such as digital x-rays, referrals and/or reports to a dental specialist about treatment.

_____ _____

Patient Signature (Parent signature if patient is under 18 years of age). Date

Doctor's Signature/ Date

Notes: