ROYCREST DENTAL CENTRE

Mr. /Ms.: ______________________________

Address: ______________________________

Date of Birth: ____________ Home Telephone: ____________ Work Tel: ____________ Cell :(________)____________

Family Doctor: ____________ Tel: ____________ Referral: ____________

Emergency Contact: ____________ Tel: ____________ Email: ____________

Financial Information: This account will be paid by: Cash ☐ Cheque: ☐ Credit Card: ☐ Insurance: ☐ Other: ☐

Person Responsible for financial matters: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐ (Please complete the form if different than above)

Name: ______________________________

Address: ______________________________

Date of Birth: ____________ Home/Tel : (______) ____________ Work/Tel: (______) ____________

Driver's Licence: ____________ OR SIN No. : ________ - ________ - ________

INSURANCE INFORMATION(if Applicable)

Insurance Company: ____________ Tel : (______)____________

Employer/ Group Policy Holder :____________ Insurance Year End: ____________

Policy # :____________ Cerificate #: ____________ ID/SIN# : ____________

Max. Coverag : ________ % Coverage for Basic : ____________ Major Restorative: ____________ Orthodontic : ____________

MEDICAL HISTORY: YES NO

1. Are you presently under the care of a physician? If so, explain ____________ ☐ ☐
2. Have you ever had a serious illness or been hospitalized? If so, explain ____________ ☐ ☐
3. Are you taking any drugs or medication at this time? Drug ____________ Reason ____________ ☐ ☐
4. Do you suffer from any allergies? (hay fever,latex,etc.) if so, which are____________ ☐ ☐
5. Do you bruise easily or having prolonged bleeding ? ____________ ☐ ☐
6. Have you ever fainted, had shortness of breath or chest pains? ____________ ☐ ☐
7. Have you ever been warned against using any medication? If so, which? ____________ ☐ ☐
8. Have you ever taken prolonged medical or non-medical drugs? Specify ____________ ☐ ☐
9. Have you ever had an adverse effect to any of the following: **Aspirin** ☐ **, Barbiturates**(sleeping pills) ☐ Antibiotics – (Penicillin , Sulfonamide ,Other). **Codeine** ☐ **Darvon** ☐ **Local Anesthetic** ☐
10. Women: Are you pregnant? Yes☐ No ☐ Have you reached menopause? Yes ☐ No ☐ Are you taking birth control? Yes ☐ No ☐
11. Do you or have you ever had any of the following: **Please** ☑ **appropriate boxes**

☐ A.I.D.S	☐ Cancer	☐ Heart disease/attack	☐ Jaundice	☐ Rheumatic/Scarlet fever
☐ Anemia	☐ Circulations problems	☐ Heart murmur	☐ Kidney Disease	☐ Sickle cell/disease
☐ Angina pectoris	☐ Congnital Heart Lesions	☐ Heart pacemaker/surgery	☐ Liver disease	☐ Sinus Trouble
☐ Anorexia nervosa	☐ Cortisone/steroid	☐ Heart rhythm disorder	☐ Leukemia	☐ Stomach/Intestinal probs.
☐ Arthritis/rheumatism	☐ Diabetes	☐ Hepatitis A/B/C	☐ Lung Disease	☐ Stroke
☐ Artificial heart valve	☐ Drug/Alcohol dependence	☐ Herpes	☐ Malignant hyperthermia	☐ Thyroid disease
☐ Artificial Joints(hip,knee)	☐ Emphysema	☐ High/Low Blood Press.	☐ Mental/Nervous disorder	☐ Tuberculosis
☐ Asthma	☐ Epilepsy or seizures	☐ H.I.V Positive	☐ Mitral valve prolapsed	☐ Ulcers
☐ Blood Disorders	☐ Glandular disorders	☐ Hodgkins disease	☐ Organ transplant/implant	☐ Venereal disease
☐ Bronchitis	☐ Glaucoma	☐ Hyper(hypo) Glycemia	☐ Psychiatric treatment	☐ Other
☐ Bulimia	☐ Head/Neck Injuries	☐ Hypertension	☐ Radiation/Chemo.	☐ None.

2. **Children Only:** Have you recently had any of the following(approximate date): ☐ Chicken Pox________ ☐ Measles ________ ☐ Mumps ________ ☐ Strep Throat ________ ☐ Tonsillitis ________

DENTAL HISTORY:

1. What is the reason for your visit today? ____________
2. When was your last dental visit? ____________ Last X-Ray? ____________
3. Have you ever had local anesthetic(freezing)? Yes ☐ No ☐ Any Complications? Yes ☐ No ☐ Please specify: ____________

GENERAL RELEASE:I, the undersigned, undertand that the information contained in the dental and medical history portion of this chart is important to my treatment. I certify that all information is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health provider as is required by this dentist and authorize this dental office to perform diagonisitic procedure as may be required to determine necessary treatment. I understand that it is my reponsibility to pay for dental treatment for both me & my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

____________ ____________ ____________

Dentist Signature Signature: ☐ Patient ☐ Parent ☐ Guardian Date