Date: ____________________

WELCOME TO OWEN SOUND DENTAL CLINIC
PATIENT REGISTRATION QUESTIONAIRE

Please answer the following questions as accurately as possible. If you have any questions, please ask your treating dentist, dental assistant, hygienist or receptionist. All information provided is strictly confidential and will remain with this office. Please print when filling out this questionnaire. If under the age of 16 please have your parent or guardian sign below.

Patient name: ______________________________(Please circle) Adult Child Guardian:_______________
Last name, First name
Preferred to be called: ___________________________Date of Birth: ____________________Age:_______

Address:____
Street Address City Province Postal Code
Home Phone: ___________________Cell Phone: ____________________Work Phone: _______________

May we call your work to speak with you? (Please circle) Yes No. Email: ____________________________
Would you prefer your appointments to be confirmed by (Please circle): Text Email Home or Work Phone
Person Responsible for the account: ____
Do you have dental insurance (Please circle)? Yes No Insurance Company: _________________________
Name of Policy Holder: ______________________________ Policy Holder's DOB: ____________________
Policy#: ________________________ Certificate #: ___________________________
Who should we thank for referring you to our office? ____

MEDICAL INFORMATION

Name of Family Physician: ______________________________Phone #: __________________________
Address: ____
Health Card#: __________________________
Are you seeking treatment from a Medical Specialist (Please circle)? Yes No Phone#: _________________
When was your last visit with your physician? ____
Have you had any change in your general health over the past year(Please circle) Yes No? If yes please explain: ____
Are you being treated for any medical condition presently(Please circle) Yes No? If yes please specify:
____
Do you have, or have you ever had any of the following conditions:

Allergies	Yes	No	Fainting or dizziness	Yes	No	Seizures	Yes
Arthritis			Hepatitis A, B, C			Shortness of Breath	
Artificial Joints			HIV or AIDS			Sinus Problems	
Asthma			Heart Problems (Attack,murmur)			Steroid Therapy	
Bone Disorders			Heart Surgery (By-pass, valve replacement, pacemaker)			Stroke	
Bleeding Disorders			High/Low Blood Pressure			Stomach Ulcers	
Cancer or tumor			Kidney or Liver Disease			Thyroid Issues	
Chest pain/Angina			Lung Disease			Tuburculosis	
Diabetes			Mental Health Issues			Do you smoke or vape?	
Drug/Alcohol Dependency			Radiation to head or neck			Epilepsy	
Respiratory Problems			Do you use cannabis if so what form (smoking, oils etc.)			Do you need to take pre-med(antibiotic) prior to dental treatment?	
Are there any conditions which you have but are not listed?			Dementia			Do you have any disabilities?(eg. Visual, mobility, hearing, developmental etc.)	

In case of emergency contact: ______________________________________Phone#: __________________
Preferred Pharmacy: ____Phone#: __________________
Please list your current prescription and non-prescription medication, or herbal supplements. If you are currently not taking any medication please print none below:

____
____
____

DENTAL INFORMATION

Pleas circle below.
Which oral hygiene aids that you use:
Manual toothbrush   Electric toothbrush   Dental floss   Interdental brushes Mouthwash
How you feel about having dental treatment:
Extremely nervous   Moderately nervous   Mildly nervous   Confident
What would you like your appointment to consist of:
Complete exam   Relief of pain today only   Repair teeth as required   Consultation regarding treatment
Please circle Yes or No for the following:

Do your gums bleed?	YES	NO
Are any of your teeth loose?	YES	NO
Are your teeth sensitive to hot or cold?	YES	NO
Are you aware that you grind or clench your teeth?	YES	NO
Have you ever had your wisdom teeth removed?	YES	NO
Is there anything that you dislike about your smile?	YES	NO
Women only are you pregnant?	YES	NO

GENERAL RELEASE

I understand and certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I understand that the practice requires at least 24 hour notice if I need to cancel my scheduled appointment or if I miss my scheduled appointment there will be a fee of $40.00 applied to my account. I understand that payment is required on the day of treatment. I consent to the performance of dental and oral surgery procedures agreed to be necessary or advised.

X____   ____
Signature of Patient, Parent or Guardian   Please Print Name of Guardian