SMILE CARE
DENTAL CENTER

32465 S Fraser Way #3
Abbotsford, British Columbia

T. **604-744-2262** E. **info@abbysmilecare.com**

Date: _____
mm / dd / yyyy

PATIENT REGISTRATION

WELCOME TO OUR OFFICE

The following information is required by the dentist to assist in proper diagnosis and treatment. It is important to have complete answers. The information is **STRICTLY CONFIDENTIAL**. Please feel free to ask the receptionist for help in completing this form.
PLEASE PRINT.

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Name: _____ Date of Birth: _____
Last First Inital mm / dd / yyyy

Address: _____
Street City Province Postal Code

Home Phone: _____ Cell: _____ Email: _____

Occupation: _____ Employer: _____ Phone: _____

Family Physician: _____ Phone: _____

Best Contact Method: ☐ Text ☐ Cell ☐ Email ☐ Home

In case of emergency, please notify: _____ Relationship: _____ Phone: _____

How did you hear about our office? _____

MEDICAL HISTORY

1. Have you ever had a serious illness or are you currently under the care of a physician? ☐ YES ☐ NO
   Specify: _____
2. Are you taking any prescription or non-prescription medication? ☐ YES ☐ NO
   Specify: _____
3. Have you ever experienced an unusual reaction from any of the following:
   ☐ Local Anesthesia ☐ Aspirin ☐ Penicillin ☐ Codeine
   ☐ Sulfonamide (sulfa) ☐ Barbiturates (sleeping pills) ☐ Iodine ☐ Other: _____
4. Do you have any allergic condition? i.e. asthma, hay fever, rash, food allergies ☐ YES ☐ NO
5. Have you been warned against taking any drug or medication? ☐ YES ☐ NO
6. Do you have or have you ever had any of the following:

☐ Heart Murmur	☐ Other Heart Condition	☐ Joint/Valve Replacement
☐ Stomach/Intestinal Problems	☐ Mental/Nervous Disorder	☐ High Blood Pressure
☐ Hyper/Hypo Glycemia	☐ Epilepsy or Seizures	☐ Low Blood Pressure
☐ Jaundice	☐ Diabetes	☐ Tuberculosis
☐ Lung Disease	☐ Venereal Disease	☐ Thyroid Disease
☐ Stroke	☐ Arthritis or Rheumatism	☐ Hepatitis
☐ Kidney Disease	☐ Cancer	☐ Liver Disease
☐ Sinus Trouble	☐ Herpes	☐ Cold Sores
☐ Eating Disorder	☐ Drug Abuse	☐ Sleep Apnea
Specify: _____	*Specify*: _____	

7. Have you had any indication of HIV infection, AIDS, or any other disorder of the immune system? ☐ YES ☐ NO
8. Do you have any blood disorders (i.e. anemia, hemophelia or thalassaemia) or bruise easily or bleed abnormally? ☐ YES ☐ NO
9. Do you have a tendency to faint or have frequent severe headaches? ☐ YES ☐ NO
10. Have you ever had any injury, surgery or radiation therapy to your face or jaws? ☐ YES ☐ NO
11. Do you have frequent earaches, ear/throat infections or hearing difficulties? ☐ YES ☐ NO
12. Do you ever experience shortness of breath or pain in your chest? ☐ YES ☐ NO
13. Do you have any organ transplants or medical implants? ☐ YES ☐ NO
14. Do you have any disease, condition or problem not listed above that you think the doctor should know about? ☐ YES ☐ NO
    Specify: _____

15. **WOMEN ONLY** - Are you pregnant? If so, when is your due date? _____ ☐ YES ☐ NO
Are you taking birth control? ☐ YES ☐ NO

IN ORDER TO AVOID COMPLICATIONS AS A RESULT OF A CHANGE IN YOUR MEDICAL CONDITION, IT IS IMPORTANT THAT YOU NOTIFY OUR OFFICE OF THESE CHANGES.

DENTAL HISTORY

1. Is there a problem you would like to take care of as soon as possible? _____
_____
2. How frequently do you see a dentist? _____ Former Dentist: _____
3. When was your last dental visit? _____ What was done? _____
4. When was your last dental cleaning? _____
5. How often do you brush your teeth? _____ Floss your teeth? _____
6. Cleaning aids presently used? ☐ Electric Brush ☐ Toothpick ☐ Waterpik ☐ Other
7. Are any of your teeth sensitive to: ☐ Cold ☐ Heat ☐ Sweets ☐ Biting
8. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Spontaneously
9. Does any part of your mouth hurt when clenched? ☐ YES ☐ NO
10. Does your jaw crack or pop when opened widely? ☐ YES ☐ NO
11. Have you experienced any growth or sore spots in your mouth? ☐ YES ☐ NO
If so, where? _____
12. Habits: Do you
- Grind or clench your teeth? ☐ YES ☐ NO
- Mouth breathe while awake or sleeping? ☐ YES ☐ NO
- Bite your lips or cheeks regularly? ☐ YES ☐ NO
- Bite on foreign objects? (pencil, fingernails) ☐ YES ☐ NO
- Smoke? ☐ YES ☐ NO
☐ Cigarettes ☐ Chewing Tobacco ☐ Vaping ☐ Marijuana
How Much? _____ Are you interested in quitting? ☐ YES ☐ NO
13. Are you interested in any of the following:
☐ Orthodontics (braces) ☐ Repairing Chipped Teeth ☐ Improved Gum Health
☐ Sleep Apnea Appliance ☐ Bleaching (whitening teeth) ☐ Improving Your Bite
☐ Closing Spaces Between Teeth ☐ Crowns (caps) ☐ Sports Mouth Guard
☐ Replacing Missing Teeth ☐ Improved Breath Odor ☐ Improving Your Smile
14. Do you have any concerns regarding your dental visit? ☐ YES ☐ NO
☐ Fear ☐ Pain ☐ Time ☐ Money ☐ Other: _____

☐ I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary, as this information may be required for my dental care.

CONSENT FOR TREATMENT

☐ I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and will assume responsibility for fees associated with these procedures.

☐ I am aware that if for any reason the insurance company does not pay the full amount for the treatment rendered, I am responsible for the balance.

_____
Patient (Parent, Guardian) Signature:

_____ _____
If Parent, Guardian, please print name: Date (mm/dd/yyyy)