Patient I.D. #

WELCOME TO JUST SMILES DENTAL

For our office records we would appreciate the following information. All information will be kept **confidential**. Thank you very much for your cooperation. PLEASE PRINT.

ADULT PATIENT (or Parent/Guardian) REGISTRATION

❒ Dr. ❒ Mr. ❒ Mrs. ❒ Ms. ❒ Miss

Date:_____/_____/_____ (M D Y)

Name: _____ Prefer. Name: _____
(last) (first) (initial)

Address: _____
(street) (city) (prov) (postal code)

Date off Birth: ____/____/____ (M/D/Y) Personal Health Number: _____ Home Phone: _____

Email address: _____ Cell Phone: _____

Employer: _____ Work Phone: _____Ext____

How did you hear about us? _____

Who should we thank for the referral? _____

Would you like to receive text/email for appointment reminder & confirmation? ❒ Yes ❒ No

CHILD REGISTRATION or ADULT UNDER GUARDIANSHIP

Name: _____ _____
(last) (first) (initial) Prefers to be called

Address: _____
(if different than above) (street) (city) (prov) (postal code)

Date of Birth: ___/___/___ (M/D/Y) Age: _____ Sex: _____ Home Phone: ( ) _____

Spouse: _____ Spouse's Phone:_____

Spouse's employer: _____ Spouse's Work Phone: _____

Emergency Contact: _____ Relationship:_____

Phone Number: ( ) _____ Alternative Number: ( ) _____

*Dental plans vary greatly. The forms, conditions and percentages of payments are contracted between you, your employer and the insurance company. It is **your responsibility** as the insurance holder to know your plan and inform us of any changes that may occur. Our office will bill your dental insurance company directly for their portion of your treatment charges. You will be required to pay the **patient portion** on each visit.*

PRIMARY DENTAL INSURANCE				SECONDARY DENTAL INSURANCE			
NAME OF INSURED				NAME OF INSURED		DATE OF BIRTH	
EMPLOYER							
INSURANCE CARRIER				INSURANCE CARRIER			
GROUP/POLICY NUMBER				GROUP/POLICY NUMBER			
I.D. NUMBER OR S.I.N.		CERTIFICATE NUMBER	DEPT. NO.	I.D. NUMBER OR S.I.N.		CERTIFICATE NUMBER	DEPT. NO.
COVERAGE PERCENTAGE: A	B	C	D	COVERAGE PERCENTAGE: A	B	C	D
LIMITS BASIC	MAJOR	ORTHO		LIMITS BASIC	MAJOR	ORTHO	
DEDUCTIBLE BASIC	MAJOR	❒ PER PERSON ❒ PER FAMILY		DEDUCTIBLE BASIC	MAJOR	❒ PER PERSON ❒ PER FAMILY	
COMP COV N/G	uSc/Rp ONLAY	mR		COMP COV N/G	uSc/Rp ONLAY	mR	

MEDICAL HISTORY Date: _____ / _____ / _____

MEDIC ALERT	

To help ensure your well being while receiving treatment in our office, please answer the following questions. All information will be considered confidential and for our records only.

	Yes	No
1. Have you ever been hospitalized or had a major operation? Specify: _____	❒	❒
2. Are you under a physician's care now?	❒	❒
3. Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma?	❒	❒

4. Are you taking any medications,or non-prescription drugs now?
   Specify: _____
5. Are you allergic to any of the following?
   ❒ Aspirin ❒ Penicillin ❒ Codeine ❒ Local Anesthetics ❒ Acrylic ❒ Metal
   ❒ Latex ❒ Sulfa Drugs ❒ Other: Specify:_____
6. Family Doctor: _____ Phone #: _____
7. Do you have or have you ever had any of the following? (please check ✔)

❒ Scarlet or Rheumatic fever
❒ Congenital heart condition
❒ Arteriosclerosis
❒ Stroke
❒ Heart Attack
❒ High/low Blood Pressure
❒ Heart Trouble
❒ Lung/breathing problems
❒ Kidney/bladder problems
❒ Stomach/intestinal problems
❒ Hepatitis A/B/C
❒ Liver Disease
❒ Diabetes
❒ Hyper-/hypo-glycemia

❒ Nervous/Mental disorder
❒ Epilepsy/Seizures
❒ Prolonged bleeding after injury
❒ Bruise easily
❒ Cortisone/steroid therapy
❒ Hives/skin rash
❒ Asthma
❒ Allergies _____
❒ Unusual reaction to any drugs
_____
❒ Pacemaker/artificial valves
❒ Artificial joints/implants
❒ Blood disorder (anemia, thalassaemia major/minor)

❒ Thyroid Disease
❒ Arthritis
❒ Severe headaches
❒ AIDS
❒ HIV Positive
❒ Cancer
❒ Cold sores
❒ Sinus trouble
❒ Frequent Ear aches
❒ Trouble hearing
❒ Swollen ankles
❒ Shortness of breath
❒ Persistent coughing

❒ Tobacco
❒ Alcohol/drug addiction
❒ Malignant hyperthermia
❒ Injury/surgery to face/jaw
❒ Tuberculosis
❒ Herpes
❒ Chemotherapy
❒ Radiation treatment
❒ Infectious disease
❒ Veneral disease

Women only. Are you?
❒ Pregnant
❒ Menopausal

DENTAL HISTORY

1. Reason for today's visit: ❒ Exam ❒ Cleaning ❒ Emergency ❒ Other _____
2. Do you have any dental concerns that you would like to have taken care of as soon as possible?
   If Yes, please elaborate: _____
3. When was your last dental visit? _____
   How frequently do you see your dentist? ❒ 6 months ❒ Yearly ❒ Other _____
   Former dentist _____
4. Check (✔) any of the following you are interested in or you have thought about:

❒ Whitening	❒ Repairing chipped teeth	❒ Improved gum health
❒ Closing spaces between teeth	❒ Wisdom teeth removal	❒ Improving your bite
❒ Straightening your teeth	❒ Crowns (caps)	❒ Improving breath odor
❒ Replacing missing teeth	❒ Sports mouth guard	❒ Improving your smile

INFORMED CONSENT/GENERAL RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services, including the use of anaesthetic as be necessary. I also understand that I assume responsibility for fees associated with these procedures and services.

Patient (Parent, Guardian) **Signature:** _____

If parent or guardian*, please print name: _____ Date: _____ / _____ / _____
M D Y

* Guardian of Child or Guardian of Adult under Guardianship