# PATIENT REGISTRATION

## PATIENT INFORMATION

full name: preferred name:

sex: O MALE O FEMALE birthdate (D/M/Y):

Are you a Canadian resident? O YES O NO

Other family members who are patients here:

If this patient is a minor, please provide name(s) of parent(s) or guardian(s):

If a custody/guardianship order is in place, provide details of who can provide authorization for dental care:

If patient is not a minor but incapable of providing consent, provide details of legally authorized healthcare representative, advocate or decision-maker:

## CONTACT INFORMATION

mobile #: home #: work #:

e-mail:

address:

city: province/state: postal/zip code:

Which is the BEST NUMBER to reach you? O MOBILE O HOME O WORK

What is your preference for confirming appointments (check one or more): O EMAIL O PHONE

## EMERGENCY CONTACT INORMATION

name: relationship: tel:

## HOW DID YOU FIND US?

O Referral. Who may we thank for inviting you to our office?

O Internet search. Which search engine or online directory?

O Walked by

## FINANCIAL INFORMATION

person financially responsible for account (if not patient):

relationship to patient:

email: telephone #:

address: O check if same as above

city: province/state: postal/zip code:

## INSURANCE INFORMATION (OUR STAFF WILL HELP YOU WITH THIS SECTION)

PRIMARY DENTAL INSURANCE

| insurance provider: | employer: | group ID: |
| --- | --- | --- |
| policy ID: | subscriber name: | subscriber birthdate (D/M/Y): |
| subscriber ID: | patient relationship to subscriber: ○ SELF ○ SPOUSE ○ DEPENDENT | |

SECONDARY DENTAL INSURANCE

| insurance provider: | employer: | group ID: |
| --- | --- | --- |
| policy ID: | subscriber name: | subscriber birthdate (D/M/Y): |
| subscriber ID: | patient relationship to subscriber: ○ SELF ○ SPOUSE ○ DEPENDENT | |

## CONSENT

White Rock Dental Group (WRDG) is a group of associated dental corporations and dentists.

### AUTHORIZATION

Upon consultation and direct consent, I authorize the dentists at WRDG to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the dentists to make a thorough diagnosis of my needs. Further to my consultation and direct consent, I authorize the dentists to perform any and all forms of treatment, medication, and therapy that may be indicated. As permitted, these authorizations extend to the dentists' associates, employees, staff, or anyone acting under or with them.

### FINANCIAL

I understand that the responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements, including insurance or otherwise, have been made.

I authorize the release of information contained in claims submitted directly to my dental insurance provider from this office. I also authorize communication of information related to my dental coverage and benefits from my dental insurance provider to this office. If allowed, I also assign my benefits payable from claims submitted electronically and authorize payment directly to this dental office.

### APPOINTMENTS

Appointments are confirmed when they are made. If I need to reschedule, I understand I must provide at least two working days' notice to avoid a charge.

### PERSONAL INFORMATION

This office collects personal information from patients for the safe and efficient delivery of dental treatment, including information used for payment of dental services. This information includes contact information, dental history, medical history, past treatment, and financial and billing information such as insurance status.

In the normal course of business, personal information may be viewed by the doctors, their associates, employees, staff, or anyone acting under or with them. It may also be shared with other dentists, dental specialists, healthcare professionals including family doctors, malpractice adjusters or health-profession regulators as necessary.

The office has a Privacy Policy for Patients, as required under the Personal Information Protection Act, and is available anytime on request or on the office website. I agree that the office can collect and use my personal information as set out above and in accordance with the law.

### NON-RESIDENTS OF CANADA

I agree I shall be governed in accordance with the laws of the Province of British Columbia, Canada. I also acknowledge and agree that the Courts of the Province of British Columbia, Canada, shall have the exclusive jurisdiction to deal with any complaints, demands, claims, disputes, causes of actions or proceedings, including whether they are based on alleged breach of contract or alleged negligence arising out of the treatment or service provided to me by the dentists, their employees, associates, staff, or anyone acting under or with them.

## I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED ABOVE

Signature of patient (or parent/guardian, or other person authorized to consent for patient)

signature: ____________________ date (D/M/Y): ____________________

name of patient: ____________________

name of person signing (if different): ____________________

# DENTAL AND MEDICAL HISTORY

patient name: today's date (D/M/Y):

## DENTAL HISTORY

previous dentist name: telephone #:

last dental visit:

What is your immediate concern?

How would you rate the condition of your mouth? ○ EXCELLENT ○ GOOD ○ FAIR ○ POOR

I routinely went to my dentist office every: ○ 3 MO ○ 4 MO ○ 6 MO ○ 12 MO ○ NOT ROUTINELY

Are you fearful of dental treatment? ○ YES ○ NO How fearful on a scale of 1 (least) to 10 (most)?

Have you had a negative dental experience? ○ YES ○ NO

Have you ever had complications from past dental treatment? ○ YES ○ NO

Have you ever had difficulty getting numb or had any bad reactions to local anaesthetic? ○ YES ○ NO

## MEDICAL HISTORY

family doctor name: telephone #:

medical specialist name: telephone #:

List all previous allergic reactions or adverse effects from any medications, rubber/latex products, other environmental sources

(foods/dyes/hayfever etc):

List all prescription medications, patches, inhalers, injections, supplements, vitamins, naturopathic medicines, over-the-counter medications,

pills/tablets that you are using regularly:

Are you currently being treated for any medical condition? ○ YES ○ NO

details:

Have there been any changes in your general health in the past two years? ○ YES ○ NO

details:

Have you ever been hospitalized for an illness or surgery? ○ YES ○ NO

details:

When was your last general medical/physical exam?

Do you go for any regular medical laboratory testing? ○ YES ○ NO

Do you currently smoke or chew tobacco products? ○ YES ○ NO

Did you previously smoke or chew tobacco products? ○ YES ○ NO quit date:

How many alcoholic beverages do you consume on average in one week?

Is there any medical condition that you wish to discuss with the doctor in private only? ○ YES ○ NO

patient name: today's date (D/M/Y):

## MEDICAL SYSTEM OVERVIEW

Indicate which of the following you presently have or previously had. Please answer honestly as these can all impact the safe provision of dental care.

### HEART AND CIRCULATION

- O heart valve repair/replacement
- O heart transplant/artificial heart
- O heart infection (infective endocarditis)
- O congenital heart disease/defect
- O high blood pressure
- O low blood pressure
- O fainting
- O atherosclerosis
- O chest pain/angina
- O heart attack
- O stents/angioplasty
- O coronary bypass surgery
- O swollen ankles (not from injury)
- O weak heart/congestive heart failure
- O stroke
- O central line/catheter
- O pacemaker/implanted defibrillator
- O irregular heart rhythm
- O atrial fibrillation

### LIVER, KIDNEYS, AND DIGESTION

- O jaundice
- O hepatitis B/C
- O autoimmune hepatitis
- O liver cirrhosis
- O alcohol-related liver disease
- O acute or chronic kidney failure
- O dialysis: Su M T W Th F Sa (circle)
- O stomach/intestinal ulcers
- O reflux/GERD
- O ulcerative colitis
- O Crohn's disease
- O irritable bowel syndrome
- O diabetes

### LUNGS

- O sleep apnea
- O difficulty breathing at rest
- O difficulty breathing on exertion
- O emphysema
- O chronic bronchitis
- O asthma
- O cystic fibrosis
- O lung transplant

### HORMONES AND IMMUNE SYSTEM

- O thyroid disorder
- O steroid therapy
- O lupus (SLE)
- O rheumatoid arthritis
- O organ transplant
- O HIV+

### CANCER

- O blood cancer
- O cancer or tumour
- O radiation therapy
- O chemotherapy

### DEVELOPMENTAL

- O autism spectrum
- O cerebral palsy
- O Down's syndrome
- O other neurodevelopmental condition

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### SENSORY

- O blindness
- O glaucoma
- O hearing impairment/deafness

### MUSCLES AND SKELETON

- O osteopenia/osteoporosis medications
- O joint replacement
- O previous joint infections
- O osteoarthritis
- O neck/back injury

### NEUROLOGICAL

- O seizures
- O multiple sclerosis
- O Parkinson's disease
- O other neurological condition

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### BLOOD AND BLEEDING

- O bleeding disorders/haemophilias
- O "blood thinner" medication

### MENTAL HEALTH

- O depression
- O dementia/Alzheimer's
- O anxiety disorder
- O mental illness
- O eating disorders
- O drug dependency
- O alcohol dependency
- O other psychiatric condition

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### WOMEN

- O trying to get pregnant
- O currently pregnant (______ weeks)
- O currently breastfeeding

IS THERE ANYTHING ELSE YOU THINK WE SHOULD KNOW OF?

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