REGISTRATION FORM

Denali Dental
405 Martin St, Unit 5, Milton, ON

**Patient Name**

First: ____________ Last: ____________ MI: ________

**Title**

Mr / Ms / Mrs / Miss

**Gender**

☐ Male ☐ Female

**Family Status**

☐ Married ☐ Single ☐ Child ☐ Other

**Birth Date**

Date: ________ Month: ________ Year: ________

**Phone**

Home: ______________________

Mobile: ______________________

**Email**

______________________

**Address**

______________________

______________________

City: ____________ Province: ________

Postal Code: ____________

**How did you hear about Denali Dental?**

☐ Friends / Family ☐ Google ☐ Facebook ☐ Instagram

☐ Walk-in ☐ Yelp ☐ Opencare ☐ Prep Doctors

☐ Newsletter Other ______________

**Emergency Contact**

Name: ____________

Relationship: ____________

Phone: ____________

**Family Doctor ( Optional )**

Name: ____________

Phone: ____________

**Family Doctor ( Optional )**

Name: ____________

Phone: ____________

**Referring Doctor ( Optional )**

Name: ____________

Phone: ____________

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**The following Information is required to enable us to provide you with the best possible dental care.**
**All information is strictly private, and is protected by doctor-patient confidentiality.**
**If you do not understand any of the questions, please ask and we would be happy to explain.**
**Please fill in the entire form.**

**Are you being treated for any medical condition at the present or have you been treated within the past year?**

☐ Yes ☐ No

If yes, what condition?

**When was your last dental visit?**

**Has there been any change in your general health in the past year?**

☐ Yes ☐ No

If yes, please explain.

**Are you taking any medication, non-prescription drugs or herbal supplements of any kind?**

☐ Yes ☐ No

If yes, please explain.

**Do you smoke or chew tobacco products?**

☐ Yes ☐ No

**Are you nervous during dental treatment?**

☐ Yes ☐ No

**Have you ever had a peculiar or adverse reaction to any medicines or injections?**

☐ Yes ☐ No

If yes, please explain.

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**Do you or have you had any of the following medical conditions**

- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Iodine
- [ ] Allergy - Latex
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Allergy - Erythromicin
- [ ] Allergy - Local Anesth
- [ ] Alzheimer's Disease
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Heart Valve
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Chest Pains
- [ ] Circulation Problems
- [ ] Contraceptive Use
- [ ] Diabetes
- [ ] Circulation Problems
- [ ] Dizziness / Fainting
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Excessive Bruising
- [ ] Fainting
- [ ] Gastro-Intestinal
- [ ] Glaucoma
- [ ] Hard To Freeze
- [ ] Hay Fever
- [ ] HBP
- [ ] Head Injury
- [ ] Hearing Disabled
- [ ] Heart Murmur
- [ ] Heart Pacemaker
- [ ] Heart Surgery
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] HIV + (AIDS)
- [ ] Hives
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] LBP
- [ ] Liver Disease
- [ ] Lung Disease
- [ ] Mental Disorders
- [ ] Multiple Sclerosis
- [ ] Nervous Disorders
- [ ] Organ / Medical Transplant
- [ ] Pacemaker
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Rheumatoid Arthritis
- [ ] Sinus Problems
- [ ] Sickle Cell Disease
- [ ] Skin Rash
- [ ] STD
- [ ] TMJ
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Wheelchair

**Are there any conditions or diseases not listed above that you have or have had?**

- [ ] Yes
- [ ] No

If yes, please explain.

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**For women only: Are you breastfeeding or pregnant? What is the expected delivery date?**

- [ ] Yes
- [ ] No

Date

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REGISTRATION FORM

**Please list any prescription or non-prescription medicine you are currently taking or have recently taken.**

______________________________

**Are you allergic to have you had a reaction to any of the following items?**

☐ Antibiotics ☐ Aspirin ☐ Codeine
☐ Darvon ☐ Local Anaesthetic ☐ Nitrous Oxide

Other: ______________________________

**Do you use any form of tobacco or wear a nicotine patch?**

☐ Yes ☐ No

**Are you dependent on alcohol or drugs?**

☐ Yes ☐ No

**If so, have you received treatment?**

☐ Yes ☐ No

**Have you ever tested HIV positive?**

☐ Yes ☐ No

**If you have ever been advised against taking any type of medication, please list them below.**

______________________________

**If you have any allergic conditions please list them below. This can include asthma, hay fever, food allergies, and metal or latex allergies.**

______________________________

**Do you bruise easily or bleed severely when you are cut?**

☐ Yes ☐ No

**Do you have severe earaches, ear or throat infections, or headaches?**

☐ Yes ☐ No

**Do you wear eyeglasses or contact lenses?**

☐ Yes ☐ No

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**Cancellation Policy**

Please know that appointment times have been reserved especially for you, and any change in the schedule affects many people. **If for any reason you are unable to keep the reserved appointment time, we ask the courtesy of two business days' notice to allow us to offer the time to another client who may be waiting for an opening.** Appointments cancelled with less than two business days' notice may be subject to a broken appointment fee, the amount of the fees is dependent on the type of the appointment. ____________ (Please initial)

**To the best of my knowledge, the above information is correct.**

**Patient / Parent / Guardian:** ______________________

**Doctor's Signature:** ______________________

**Signature:** ______________________

**Date:** ______________________

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