NORBERRY
Dental Centre

CONFIDENTIAL PATIENT REGISTRATION & HEALTH HISTORY

PATIENT INFORMATION

Name _____ Sex F ❑ M ❑

Address _____

City/Prov. _____ Postal Code _____

Home # _____ Business # _____ Cell # _____

Birth Date _____ (YEAR MONTH DAY) Employer _____ Occupation _____

In case of emergency who should be notified? _____ Relationship _____

Emergency Phone Numbers: Work # _____ Home # _____

Person financially responsible for account (if different from patient) _____

Relationship to patient _____ Is Patient covered by Insurance? Yes ❑ No ❑

PLEASE COMPLETE THIS SECTION IF YOU ARE COVERED BY INSURANCE

INSURANCE

The following information is necessary for proper insurance coverage:

Subscriber Name _____

Subscriber Date of Birth _____ S.I.N. _____

Insurance Company _____ Employer _____

Group/Plan # _____ Subscriber ID # _____

Is Patient covered by additional Insurance? Yes ❑ No ❑

PLEASE COMPLETE THIS SECTION IF YOU HAVE MORE THAN 1 INSURANCE COMPANY:

Second Subscriber Name _____ Date of Birth _____

Insurance Company _____ Employer _____

Group/Plan # _____ Subscriber ID # _____

DENTAL HISTORY

Whom may we thank for referring you? _____

Reason for today's visit _____

Former Dentist _____

Date of last Dental visit _____ Date of last dental x-rays _____

Please indicate if you have concerns with any of the following

- ❑ Bad breath
- ❑ Clicking/popping jaw
- ❑ Grinding Teeth
- ❑ Jaw pain/tenderness
- ❑ Loose teeth
- ❑ Broken Fillings
- ❑ Periodontal Treatment
- ❑ Sensitivity - to what? _____
- ❑ Thumb Sucking
- ❑ Burning Sensation in mouth
- ❑ Chewing on one side of mouth
- ❑ Smoking
- ❑ Dry mouth
- ❑ Orthodontic Treatment
- ❑ Gums swollen/tender/bleeding
- ❑ Lip/Cheek biting
- ❑ Mouth breathing
- ❑ Pain around ear
- ❑ Sores or growths in your mouth
- ❑ Food collecting between teeth

How often do you brush? _____

How often do you floss? _____

OVER →

MEDICAL HISTORY

Physician's Name _____ Phone # _____

Date of last visit _____

Have you had any serious illnesses or operations? Yes ❑ No ❑

Describe _____

Have you ever had a blood transfusion? Yes ❑ No ❑ Approx. Date _____

Women – Are you pregnant? Yes ❑ No ❑ Nursing? Yes ❑ No ❑

– Taking Birth Control? Yes ❑ No ❑

ARE YOU CURRENTLY TAKING ANY MEDICATION, DRUGS OR PILLS? Yes ❑ No ❑

Please list and describe _____

_____

_____

ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY MEDICATION? Yes ❑ No ❑

Please list and describe _____

_____

_____

Check if you have any of the following.

- ❑ AIDS, HIV
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Circulatory Problems
- ❑ Diabetes - Type I or II
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Cortisone Treatments
- ❑ Hepatitis
  Type _____
- ❑ High Blood Pressure
- ❑ Joint Disease
- ❑ Kidney Disease
- ❑ Latex Allergy
- ❑ Liver Disease
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Lung Disease
- ❑ Rheumatic Fever
- ❑ Skin Rash
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Sexually Transmitted Disease
- ❑ Other _____

Additional Comments: _____

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_____

AUTHORIZATION: ALL PATIENTS OR GUARDIANS MUST SIGN

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I understand that I am financially responsible for all charges **whether or not** paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits, while maintaining compliance with privacy legislation. I authorize the use of this signature on all insurance. I authorize release of information in my electronic claim submission to my insurance company plan administration.

_____ _____

Signature of patient or guardian **Today's Date**