PATIENT REGISTRATION

Chapman Mills **Dental**

We **love** to see you smile

Date:

Name: **Prefers to be called:**

Address:

City: **Province:** **Postal Code:**

Home phone: **Cell Phone:**

Birthdate:
MM/DD/YY **Age:**

Place of Employment: **Position:**

Would you like to receive email appointment confirmations?
☐ Yes ☐ No **Email:**

Marital status, please circle one:
☐ single ☐ married ☐ widowed ☐ divorced ☐ separated

If Married (this is used for contact information only)

Spouse's Name: **Place of Employment:**

Spouse's Cell Phone:

www.chapmanmillsdental.com

"Our modern technology ensures you are in good hands"

Dr. John Fayad

Chapman Mills **Dental**
info@chapmanmillsdental.com
613-823-4001 613-823-2930
50 Marketplace Avenue, Unit #11
Ottawa, ON K2J 5G3

Closest living relative (not living with you):

Name: **Phone:**

Reffered by (check only 1):
■ Doctor ■ Patient ■ Staff **Name:** **Internet:**

Sign:

MEDICAL HISTORY

Your answers are for our records only and will be considered confidential.

Gender: ■ Male ■ Female **Name of your current Physician:**

Physician's Address: **Physician's Phone number:**

When was your last physical examination (MM/DD/YY):

DENTAL INSURANCE INFORMATION

This information is needed for electronic submissions to your insurer.

Primary Insured's Name: **Primary's DOB:**

Insurance Company: **Primary'sPolicy#** **Primary's ID#**

Secondary Insured's Name **Secondary's DOB:**

Insurance Company: **Secondary's Policy#** **Secondary's ID#**

Reason for your visit today: ■ Examination ■ Emergency ■ Other:

Is there a dental issue you would like treated immediately? ■ No ■ Yes, namely:

MEDICAL INFORMATION

Oral health and general health are directly related...

Are you in generally good health? ■ Yes ■ No

Has there been any change in your general health with the year? ■ Yes ■ No

Are you under a physician's care? ■ Yes ■ No

If yes, for what condition(s)?

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

If so, please list here:

Have you been hospitalized or had a serious illness within the past 5 years? ■ Yes ■ No

If yes, what reason?

CARDIOVASCULAR SYSTEM

About your heart...

Do you have or have you ever had any of the following (please circle):

■ None ■ Heart trouble ■ Heart attack ■ Stroke ■ Coronary insufficiency
■ Damaged heart valves ■ Congenital heart disease ■ Rheumatic heart disease ■ Heart murmur

Do you experience chest pain after exertion? ■ Yes ■ No

Do you have a cardiac pacemaker? ■ Yes ■ No

Do you have any blood pressure problems? ■ Yes ■ No

If yes please circle: ■ High ■ Low

CENTRAL NERVOUS SYSTEM

Brain, spinal cord and nerves are all connected...

Epilepsy?

Fainting spells?

Seizures?

Emotional Disturbances

Do you follow any treatment for a nervous disease?

RESPIRATORY SYSTEM

Your lungs are important too...

Do you have or have you ever had Tuberculosis?

Is there any history of Tuberculosis in your family?

Do you have any sinusitis or sinus trouble?

Do you have Emphysema, Chronic Bronchitis or Asthma?

DIGESTIVE SYSTEM

A series of organs and glands that help process food and regulate metabolism...

Do you have stomach ulcers?

Do you have or have you ever had ■ Hepatitis ■ Jaundice ■ Liver Disease?

ENDOCRINE SYSTEM

The system of glands that release hormones which regulate your body metabolism.

Do you have Diabetes? ■ Yes ■ No

Do you have Hypothyroidism? ■ Yes ■ No

Do you have Hyperthyroidism? ■ Yes ■ No

ALLERGIES

Are you allergic to or have you acted adversely to the below mentioned:

Local Anaesthetics ■ Yes ■ No

Antibiotics, Penicillin, or Sulpha drugs? ■ Yes ■ No

Barbiturates, sedatives, or sleeping pills? ■ Yes ■ No

Aspirin? ■ Yes ■ No

Codeine or other narcotics? ■ Yes ■ No

Other? ■ Yes ■ No

Do you have Asthma or Hay fever? ■ Yes ■ No

Do you have or have you ever had Hives or Skin rash? ■ Yes ■ No

△ If you answered yes to any of the allergy questions, please provide more information below.

GENITOURINARY SYSTEM

Organs in the reproductive and urinary systems...

Do you have or have you ever had kidney trouble? ■ Yes ■ No

Have you been exposed to the HIV virus? ■ Yes ■ No

Do you have AIDS? ■ Yes ■ No

BONE AND JOINTS

Do you have one of the below mentioned conditions:

■ Arthritis ■ Inflammatory Rheumatism ■ Bone infection ■ Osteoporosis?

NEOPLASMS

Do you have or have you ever had:

■ Tumor or malignancy ■ Chemotherapy or radiation therapy

MISCELLANEOUS

A few lifestyle questions...

Are you wearing, or do you wear contact lenses? ■ Yes ■ No

Do you drink alcohol? ■ Yes ■ No

If yes, how much and how often?

Do you smoke or use tobacco? ■ Yes ■ No

If yes, how much and how often?

MEDICATIONS

Are you taking any of the following medications?:

Antibiotics or sulfa drugs? ■ Yes ■ No

Anticoagulants (blood thinners)? ■ Yes ■ No

Medecine for high blood pressure? ■ Yes ■ No

Tranquilizers? ■ Yes ■ No

Codeine or other narcotics? ■ Yes ■ No

Vitamins or natural remedies? ■ Yes ■ No

Others? ■ Yes ■ No

△ If you are taking any medications listed above, please give details of the name of the medication, the dose and frequency, and the reason for use:

WOMEN

Good oral health and nutrition are particularly important during pregnancy...

Are you pregnant? ■ Yes ■ No

Are you nursing? ■ Yes ■ No

Are you taking Oral Contraceptives or Hormonal Therapy? ■ Yes ■ No

DENTAL HISTORY

Tell us about your smile.

What is your chief complaint about your teeth?

How would you like us to help you?

Are you experiencing any discomfort or pain at this time? ■ Yes ■ No

Are you satisfied with the appearance of your teeth? ■ Yes ■ No

Are you able to eat and chew foods satisfactorily? ■ Yes ■ No

Do you have headaches, earaches or neck pain? ■ Yes ■ No

Do you have any problems with your jaw joints? ■ Yes ■ No

Do you have problems with your bite? ■ Yes ■ No

Have you had serioustrouble/bad experience associated with previous dental treatment? ■ Yes ■ No

If yes, please explain here:

ADDITIONAL INFORMATION

If there is anything in your medical and dental history that we have not specifically asked about, of which we should be aware, please explain:

RESPONSIBILITY AND CONSENT

I hereby authorize and request the performance of dental services for myself of for:

I hereby give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatments. These records may include study models, photographs and x-rays, which may be used for dental education and used in dental publications. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment and its fee. I believe that information given in the six pages of this medical and dental history to be true to the best of my knowledge.

Signature of Patient: **Signature of Doctor:**

Date: **Date:**