WhiteSummit
dental hygiene clinic

Patient Registration

Date _____
Day Month Year

Personal Info

☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Other _____

NAME _____
Last First Middle

ADDRESS _____
Street City Prov/State Postal/Zip

BIRTHDAY _____ AGE _____ SEX _____ MARITAL STATUS _____
Day Month Year

MOBILE #(___) _____ ☐ Preferred Phone HOME # (___) _____ ☐ Preferred Phone WORK #(___) _____ ☐ Preferred Phone

WORK E-MAIL _____ ☐ Preferred E-mail HOME E-MAIL _____ ☐ Preferred E-mail

EMPLOYER _____ OCCUPATION _____

SPOUSE'S NAME _____ PHONE # (___) _____

EMPLOYER _____ OCCUPATION _____

Ins.

INSURANCE PROVIDER

☐ Self Funded ☐ Employer Funded ☐ Combination Funded

GROUP/POLICY #	ID/SUBSCRIBER/SIN	DIVISION

COVERAGE PERCENTAGE/INFO

BASIC MAJOR

DEDUCTIBLES

Health History

1. Reason for today's visit: ☐ Consult ☐ Cleaning ☐ Whitening ☐ Emergency ☐ Other _____
2. Is there a dental problem you would like taken care of as soon as possible? _____
3. How frequently do you see your dental care provider? ☐ 3 Months ☐ 6 Months ☐ Yearly ☐ Other _____

   Dentist _____ Phone _____ Last Visit? _____

   Last Cleaning _____ Last full louth series of x-rays _____

4. Have you been given oral hygiene instruction in: ☐Brushing ☐Flossing ☐Other _____
5. Brushing: ☐Vigorous ☐Light How Often? _____ Brush Type? ☐Electric ☐Manual
6. How often do you floss? _____
7. Cleaning aids used: ☐Toothbrush ☐Toothpaste ☐Floss ☐Rinses ☐Stimudents ☐Toothpick ☐Other _____
8. Are any of your teeth sensitive to: ☐Cold ☐Sweets ☐Heat ☐Sour ☐Other _____
9. Do your gums bleed when: ☐Brushing ☐Flossing ☐Spontaneously
10. Is your sugar intake: ☐High ☐Medium ☐Low
11. Have you ever had, or do you now have any of the following? (check all that apply)

☐ Bridges	☐ Lost filings	☐ Bite appliance/night guard	☐ Gum treatments
☐ Partial Dentures	☐ Extractions	☐ Swelling or pain in your mouth or jaw	☐ Gag easily
☐ Full Dentures	☐ Loose teeth		☐ Difficulty opening or closing your jaw
☐ Root Canal Fillings	☐ Orthodontic treatment	☐ Injuries to your face or jaw	
☐ Dental Implants	☐ Bite adjustment	☐ Surgery in your mouth	

	Yes	Unsure	No
12. Do you find your mouth is dry?	☐	☐	☐
13. Do you chew on only one side of your mouth? If so, why?	☐	☐	☐
14. Does any part of your mouth hurt when clenched?	☐	☐	☐
15. Does your jaw pop or crack when opened widely?	☐	☐	☐
16. Do you have any pain in your ears?	☐	☐	☐
17. Have you experienced any growths or sore spots in your mouth? If so when?	☐	☐	☐
18. Do you - Grind of clench your teeth during the day or night?	☐	☐	☐

Over

	Yes	Unsure	No
- Mouth breathe while awake or asleep?	☐	☐	☐
- bite your lips or or cheeks regularly?	☐	☐	☐
- hold any foreign objects with your teeth? (i.e. pipe, pencils, nails)	☐	☐	☐

19. Do you currently use tobacco products? If so, which ones? _____
20. Do you or have you ever used: ☐ Alcohol ☐ Cocaine ☐ Marijuana ☐ Crystal Meth ☐ Heroin
21. Mark any of the following you are interested in or have thought about:

☐ Orthodontics (braces)	☐ Repairing chipped teeth	☐ Improving gum health	☐ Nightguard (splint)
☐ Bonding (Straightening)	☐ Bleaching (whitening teeth)	☐ Improving your bite	
☐ Closing spaces between teeth	☐ Crowns (caps)	☐ Improving breath oder	
☐ Replace missing teeth	☐ Sports mouth guard	☐ Improving your smile	

22. Would you rate your current dental health as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
23. Do you have any emotional concerns regarding your dental visit? ☐ Fear ☐ Pain ☐ Time ☐ Money ☐ Embarrassment
24. Do you visit a physician regularly? For regular check-up or other reasons? _____

Physician _____ Phone _____ Last Visit? _____

25. Have you ever had a serious operation or Illness? Please explain? _____
26. Are you taking any drugs or medicine including non-prescription drugs, over the counter drugs, or herbal medicine? Please specify which, and for what reason. _____
27. Are you allergic to or have you had reactions to:

☐ Local anesthetics	☐ Iodine
☐ Penicillin or other antibiotics	☐ Any metals (e.g. nickel, mercury, etc.)
☐ Sulfa drugs	☐ Latex
☐ Barbiturates, sedatives, or sleeping pills	☐ Other _____
☐ Asprin	

28. Have you been advised by your physician to take antibiotics prior to dental treatment?	☐ Yes	☐ No
29. Have you ever had any excessive bleeding requiring any special treatment?	☐ Yes	☐ No
30. Are you on any blood thinner medication? (i.e Warfarin, Acetylsalicylic acid, etc.)	☐ Yes	☐ No
31. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you're tired?	☐ Yes	☐ No
32. Have you lost or gained more than 10 pounds (4.5kg) in the last 12 months?	☐ Yes	☐ No
33. Women - Are you pregnant? When is your due date? _____	☐ Yes	☐ No

34. Indicate any that you have had or do have:

☐ Heart disease or attack	☐ Headaches	☐ Cortisone/ steroid medicine	☐ Fainting or dizzy spells
☐ Angina pectoris	☐ Mental health challenges	☐ Glaucoma	☐ Nervousness
☐ High blood pressure /or low	☐ Brain injury	☐ Hepatitis A, B or C (please indicate)	☐ Psychiatric treatment
☐ Heart murmur/Mitral valve prolapse	☐ Lung or breathing problems	☐ Liver DIsease	☐ Bruise easily
☐ Congestive heart failure	☐ Tuberculosis	☐ Yellow jaundice	☐ Multiple sclerosis (MS)
☐ Rheumatic fever	☐ Asthma	☐ HPV (Human Papilloma Virus)	☐ AIDS or AIDS related complex
☐ Congenital heart disease	☐ Hay fever	☐ Blood Transfusion	☐ Malignant hypothermia
☐ Artificial heart valve	☐ Sinus trouble	☐ Lupus	☐ Cancer
☐ Heart pacemaker	☐ Diabetes	☐ Alzheimer's disease. Stage?	☐ Celiac disease
☐ Heart surgery	☐ Thyroid disease	☐ Dementia	☐ Other
☐ Artificial joint (knee, hip, etc.)	☐ Cancer, leukemia	☐ HIV	_____
☐ Anemia	☐ X-ray or Cobalt treatment	☐ Hemophilia	_____
☐ Stroke	☐ Chemotherapy	☐ Venereal disease (Syphilis, Gonorrhea)	
☐ Kidney trouble	☐ Arthritis	☐ Cold sores	
☐ Ulcers	☐ Rheumatism	☐ Epilepsy or seizures	

Informed Consent and General Release

I state that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical/Dental history and I consent to my other care providers being contacted if necessary. I authorize the dental care provider to perform diagnostic, dental procedures, x-rays, photographs or any other diagnostic aid deemed appropriate by the dental care provider and any services including the use of anesthetic as may be necessary. I also understand that I assume responsibility for any and all fees associates with these services provided to me or my dependents.

I understand payment is due in full at time of treatment. I also consent to the collection, use, retention and disclosure of personal information as required for my own and my dependents care.

APPOINTMENTS: We operate in an environment of mutual respect. Remember that once you have made an appointment, this time is reserved especially for you; therefore at least **72 HOURS NOTICE MUST** be given if cancelation is absolutely necessary. If less than 72 hours notice is given, a fee of $50.00 will be charged.

Patient (Parent/Guardian/Caregiver) Signature: _____

If Parent/Guardian/Caregiver, Print Name: _____ Date: _____
Day Month Year