WORLD DENTAL CLINIC

WELCOME TO OUR OFFICE

(FOR OFFICE USE ONLY)

Date _____

I.D. # :_____

MEDICAL ALERT	

REGISTRATION INFORMATION

The patient is an: Adult ☐ Child ☐ Adult under guardianship ☐ Guardian _____

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

Name: last name | first name | Initial | prefers to be called

Address: street | Apt. # | city | postal code

Bus. Phone: ( ) _____-_____ May we call you at work? Yes ☐ No ☐

Home Phone: ( ) _____-_____ Age: _____ Sex: _____Marital Status: _____

Cell Phone: ( ) _____- _____, email address: _____@ _____

Birth Date: Mo. ____ Day ____ Year _____

Employer: _____Occupation: _____

Whom may we thank for referring you? _____

Person responsible for account: _____ S.I.N. of this person: _____

MEDICAL PRIORITY

Family Physician: name | address | phone

Are you under the care of a Medical Specialist? Yes ☐ No ☐ Type of Specialist:

name | address | phone

In case of emergency, please contact: name | phone

INSURANCE INFORMATION

Do you have insurance? Yes ☐ No ☐ Insurance Co. Name: _____

Insurance Holder's Name: _____Name of Spouse: _____

Birth Date of Insurance Holder: Mo._____ Day _____ Yr. _____

Policy No.: _____ Certificate No.: _____ Group No.: _____ Division No.: _____

Maximum Coverage (Yearly): $_____ Percentage Covered: _____% Deductible: $ _____

Do you have two insurance policies? Yes ☐ No ☐ If yes, please fill out the section below:

Second Insurance Co. Name: _____Insurance Holder's Name: _____

Birth Date of Insurance Holder: Mo._____ Day_____ Yr._____

Policy No.: _____ Certificate No. _____Group No.: _____ Division No.: _____

HEALTH HISTORY

	Yes	No
1. Are you currently receiving care from a physician? _____	☐	☐
2. Were you ever seriously ill or hospitalized? _____	☐	☐
3. Are you currently on any drugs or medications? _____	☐	☐
4. Please indicate if you have a serious reaction to any of the following medication: Antibiotics ☐ Sleeping pills ☐ Antibiotics ☐ Codein ☐ Darvon ☐		
5. Please let us know if you have been warned against taking any medication_____	☐	☐
6. Have you ever used medicinal or non-medicinal drugs on a regular basis? _____	☐	☐
7. Do you have any allergies we should know about? _____	☐	☐
8. Are you a smoker? _____	☐	☐
9. Have you ever fainted, felt out of breath, or had chest pains? _____	☐	☐

Please indicate if you have or had any of the following:

☐ A.I.D.S.	☐ Cancer	☐ Heart murmur	☐ Liver disease	☐ Sinus trouble
☐ Alcohol Dependence	☐ Circulation problems	☐ Heart pacemaker/surgery	☐ Leukemia	☐ Stomach/intestinal
☐ Anemia	☐ Congenital heart lesions	☐ Heart rhythm disorder	☐ Lung disease	☐ Stroke
☐ Angina pectoris	☐ Cortisone/steroid	☐ Hepatitis A/B/C	☐ Malignant hyperthermia	☐ Thyroid disease
☐ Anorexia nervosa	☐ Diabetes	☐ Herpes	☐ Mental disorder	☐ Tuberculosis
☐ Arthritis/rheumatism	☐ Drug dependence	☐ High/low blood pressure	☐ Mitral valve prolapse	☐ Ulcers
☐ Artificial heart valve	☐ Emphysema	☐ H.I.V. positive	☐ Organ transplant/implant	☐ Venereal disease
☐ Artificial joints	☐ Epilepsy or seizures	☐ Hodgkins disease	☐ Osteoporosis	☐ Other
☐ Asthma	☐ Glandular disorder	☐ Hyper (Hypo) glycemia	☐ Psychiatric treatment	☐ None
☐ Blood disorders	☐ Glaucoma	☐ Hypertension	☐ Radiation/Chemotherapy	
☐ Bronchitis	☐ Head/neck injuries	☐ Jaundice	☐ Rheumatic/Scarlet fever	
☐ Bulimia	☐ Heart disease	☐ Kidney disease	☐ Sickle cell disease	

10. **Women:** Are you pregnant? ☐ Y ☐ N Menopause? ☐ Y ☐ N Birth control? ☐ Y ☐ N

Children: Please indicate if you had any of the following:

☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Strep Throat ☐ Tonsilitis

DENTAL HISTORY

	Yes	No
1. Please indicate the reason for today's visit: ☐ Examination ☐ Emergency ☐ Other		
2. Approximately how often do you see a dentist? _____		
3. How often do you brush? _____		
4. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other		
5. Have your gums bled when brushing or flossing? _____	☐	☐
6. Do your gums feel swollen or tender? _____	☐	☐
7. Do you feel that you have bad breath? _____	☐	☐
8. Do you experience any popping/clicking in your jaw joints? _____	☐	☐
9. Do you grind or clench your teeth? _____	☐	☐
10. Does food catch between your teeth? _____	☐	☐
11. Have you ever had local anesthetic (freezing)? _____	☐	☐
12. Have you ever had complications due to anesthetics? _____	☐	☐
13. Please indicate if you had any of the following treatments done:		
☐ Crowns or Caps ☐ Full or Partial Dentures ☐ Periodontal (Gums) ☐ Bridgework/Orthodontic (Braces) ☐ Root Canal		
14. Are you dissatisfied with the appearance of your teeth? _____	☐	☐

Privacy Consent and General Release:

Privacy of your personal information is as important part of your office as providing you with quality dental care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and as clear as possible about the way in which we handle your personal information. All our staff members who come into contact with your personal information are trained in the appropriate uses and protection of your personal information. I, the undersigned, understand that the data contained in the dental and medical history portion of this chart is important to treatment. I certify that all the information is correct and that I have not knowingly omitted data. I consent to the release of medical information my medical doctor or other health provider as is required by World Dental Clinic. I authorize World Dental Clinic to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____	_____	_____	_____
Signature	Print Name	Reviewed by Dentist	Date