**NEW PATIENT REGISTRATION**

First Name: Mr. /Miss. / Mrs. / Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name : \_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_\_\_\_ HHome Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone :\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(D/ M/ Y)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Province \_\_\_\_\_\_\_\_\_\_\_ Postal code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Addres\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Number : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time you saw your dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for coming\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any pain\_\_\_\_\_\_\_\_\_\_

( where does it hurt ) Lower left \_\_\_\_\_ Upper Left \_\_\_\_\_ Lower Right \_\_\_\_ Upper Right \_\_\_\_

Is it swollen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did you heard about our Office\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of the appointment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your unable to keep the appointment we require **48 hours** notice, otherwise you may be charged for the time lost.

**WELCOME**

Thank you for selecting our dental healthcare team ! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions of need assistance, please ask us - we will be happy to help.

The data on this confidential questionnaire is essential to render to best professional care. We appreciate your co-operation in fillit out carefully, so that we will have accurate records. PLEASE PRINT. *Thank you.*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| MEDICAL HISTORY |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| When did you have your last medical examination ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |  | | | |
|  | **Unfavorable Drug Reactions, or Allergies to:** | | | |
| Are you taking any medication? | No | Yes | \_\_\_\_\_\_\_\_\_ | Local Anaesthetics ("freezing")? | No | Yes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any serious illness? | No | Yes | \_\_\_\_\_\_\_\_\_ | General Anaesthetics? | No | Yes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any serious operations? | No | Yes | \_\_\_\_\_\_\_\_\_ | Penicillin? | No | Yes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Heart or blood pressure problems ? | No | Yes | \_\_\_\_\_\_\_\_\_\_ | Erythromycin? | No | Yes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Blood disorders or bleeding tendencies? | No | Yes | \_\_\_\_\_\_\_\_\_\_ | Other Antibiotics ? | No | Yes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Rheumatic fever? | No | Yes | \_\_\_\_\_\_\_\_\_ | Aspirin? | No | Yes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Lung or breathing problems? | No | Yes | \_\_\_\_\_\_\_\_\_ | Codeine? | No | Yes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Liver or kidney problems? | No | Yes | \_\_\_\_\_\_\_\_\_ | Other tranquilizers, sedatives and pain killers? | No | Yes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Stomach or intestinal problems? | No | Yes | \_\_\_\_\_\_\_\_\_ | Have you had ANY warnings against taking ANY medications? | No | Yes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Fainting or dizzy spells? | No | Yes | \_\_\_\_\_\_\_\_\_ | Do you smoke? | No | Yes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Diabetes? | No | Yes | \_\_\_\_\_\_\_\_\_ | Do you use alcohol? | No | Yes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Epilepsy? | No | Yes | \_\_\_\_\_\_\_\_\_ | Do you drink tea or coffee? | No | Yes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Allergies to food; skin rash; asthma; hay fever; others? | No | Yes | \_\_\_\_\_\_\_\_\_ | **FOR WOMEN ONLY :**  **are you pregnant or think you may be pregnant ? No Yes**  **If yes, when are you due? Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Are you nursing ? No Yes** | | | |
| **Have you ever tested positive for :** | | | |
| Hepatitis? | No | Yes | \_\_\_\_\_\_\_\_\_ | Have you ever been hospitalized? | No | Yes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| A.I.D.S. (HIV)? | No | Yes | \_\_\_\_\_\_\_\_\_ |  | | | |
| Tuberculosis? | No | Yes | \_\_\_\_\_\_\_\_\_ | **Is there ANYTHING ELSE concerning your health that we should know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |

## Financial Policies.

1. Payments are always due at the time of treatment , unless dental Insurance is in effect, in which case the portion not covered by your insurance (Co-payment) will be due and must be paid the same date of the appointment.

2. Overdue accounts will be charged an interest rate of 2% per month, and severely overdue accounts may be sent to collections.

3. Please be aware that appointments cancellation must be done 48 hours (2 days) prior the appointment date, otherwise you will be penalized with CAD$50 per every 15minute scheduled for your appointment. You can always email us at info@towncentredentalclinic.ca or call 416-296-1717 to cancel or change your appointment. Feel free to leave a voice mail if we do not answer the call.

**I read, understand and agree to the financial policies stated by Town Centre Dental Clinic.**

**Patient's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

About us:

Town Centre Dental Clinic has been providing the Scarborough Community with a wide variety of services for over Thirty years. From dental implants to specialized whitening techniques. We are the Scarborough dentist that focuses on the quality of care that you deserve. Our services are in English, Spanish and Persian.

Services:

Fillings, Bridges, Crowns, Cosmetic Dentistry, Teeth Whitening, Dental Implants, Orthodontics, Family Dentistry, Scaling and Root Planning, Root Canal Therapy, Oral Hygiene Instructions, Wisdom Teeth Extraction, Guards, Bite Appliances, Dentures, Partial Dentures, Snoring appliances