



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 needs, please complete each section
of this form in ink. If you have any questions,
please ask – we are happy to help.

Patient Registration

Last Name: _____ First Name: _____ Date of Birth: _____ Sex: M/F/Other
Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____ Bus. Phone: _____
Email: _____ Preferred Contact Method: Home / Cell / Bus. / Text
Height: _____ Weight: _____ Alberta Health Care Number: _____
To whom may we thank for your referral? Google, Website, Facebook, Sign, Community Newsletter,
Other (please specify): _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Scheduled Appointments

Please know that appointment times have been reserved for you and any change in the schedule affects many people. If, for any reason, you are unable to keep the reserved appointment time, we ask the courtesy of two business days' notice to allow us to offer the time to another patient who may be waiting. Broken appointments cancelled with less than the required notice may be subject to a fee.

Initial: _____

Patient Authorization

I hereby authorize the clinic to take x-rays, study models, photographs, scans or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs.

Initial: _____

Fees/Payment

I understand that I am fully responsible for the total fee at the time of service. **I have chosen to assign my benefits, payable from claims submitted electronically to Design Dentistry and acknowledge that the patient portion (or estimated patient portion) is due at the time of service**

Initial: _____

Online Communication System

We invite you to participate in our online system. Features include: requesting appointments online, receiving reminders by email or text message, confirmation of my appointment by email or text message, patient satisfaction and special event news. I agree to provide my email address for contact purposes and understand I can choose my settings and unsubscribe at any time.

Initial: _____

Please continue to the next page.

Patient Medical History

1. Have you had a medical examination in the last year? Yes / No
2. Have you been a patient in the hospital during the past two years? Yes / No
 - If yes, please specify: _____
3. Please state your physician's name: _____ Phone: _____
4. Have you been advised to take antibiotic premedication before dental visits? Yes / No
5. Are you presently taking any medication? Yes / No
 - If yes, please list all medications you are currently taking or provide your pharmacy info so that we might request a current list:

6. Do you have allergies to any medications? Yes / No
 - If yes, please specify: _____
7. Do you use tobacco products, marijuana, cocaine, or any uncontrolled substances? Yes / No
 - If yes, please specify: _____
8. For WOMEN only:
Are you pregnant? Yes / No # of months _____ contraceptive pills? Yes / No

Do you have any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Stomach | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Complications/ Ulcers | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever/ Allergies | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Complications | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hepatitis/ Jaundice | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Joint Replacement or | <input type="checkbox"/> Sexually Transmitted |
| <input type="checkbox"/> Fainting/ Seizures | <input type="checkbox"/> Implant | <input type="checkbox"/> Disease |
| <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> Kidney Diseases | <input type="checkbox"/> Other _____ |

I, _____, certify that I have provided accurate and complete registration information and have not knowingly omitted anything.

Signature: _____ Date: _____

FOR OFFICE USE ONLY: Medical History Review

Dentist's Signature: _____