auroradentalcentre **Patient Registration Form**

visit our video website at auroradentalcentre.com

Personal Information

Name:		Date of Birth:
Address:	City:	Postal Code:
Home Phone:		Cell Phone:
Email Address:		
Emergency Contact:	Relationship:	Phone#:
Are Family Members Patients of our office? ☐ Yes ☐No Names:		
How did you hear about our office? ☐ Website ☐ Google Reviews ☐ Live in Area ☐Saw Sign ☐Friend/Family: (if so, who?) ☐ Other:		

Financial / Insurance Information

At Aurora Dental Centre payment is due when services are rendered. If you have dental insurance, we will submit the claim on your behalf. We accept Visa, MasterCard, Debit, Cheques and Cash as method of payment. Our fees are based on the ODA Fee Guide for the current year. If you have any questions regarding our fees, please inquire.

Person responsible for your account:

☐ Self ☐Parent / Guardian ☐Spouse ☐Other: _____

Primary Dental Insurance		**Secondary Dental Insurance**	
Policy Holder's Name:		Policy Holder's Name:	
Date of Birth:		Date of Birth:	
Insurance Company:		Insurance Company:	
Policy#:	ID#:	Policy#:	ID#:
Employer:		Employer:	

I, understand, state that I have completed all information forms accurately, without knowingly omitting any information. On the basis of confidentiality, I hereby consent to the release and transfer of any patient information and dental records within my file for dental insurance purposes including submitting dental claims or pre-determinations or for any inter-practitioner communication. I agree that Aurora Dental Centre has obtained informed consent from me with respect to the collection, use, and disclosure of my personal health information. If asked, I will be provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection Act, 2004.

Signature: _____ Date: _____

Patient or Parent / Guardian

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Medical History

Patient Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of Family Doctor: _____Phone#: _____
Name of Medical Specialist: _____Phone#: _____
Date of Last Physical Examination: _____

Do you have or have you ever had any of the following? (Please check)

□Heart Problems	□Heart Value Replacement/Repair	□Heart Murmur	□Stroke
□High Blood Pressure	□Pacemaker	□Asthma	□Shortness of Breath
□Rheumatic Fever	□Mitral Valve Prolapse	□Lung Disease	□Tuberculosis
□Cancer/Leukemia	□Steroid Therapy	□Diabetes	□Stomach Ulcers
□Arthritis	□Seizures (epilepsy)	□Kidney Disease	□Thyroid Disease
□Drug/Alcohol Dependency	□ Hepatitis/Liver Disease	□Jaundice	□HIV or AIDS
□Prosthetic/Artificial Joints	□Chemotherapy/Radiation	□Bleeding Disorder	
□Smoking/Chewing Tobacco	□Osteoporosis/Low Bone Density		

□Please Specify: _____

Are there any conditions or diseases not listed above that you have or ever had? □Yes □No
If so, what?

_____

Are you taking any medication, non-prescription or herbal supplements of any kind? □Yes □No
If yes, please list_____

Have you ever had an allergic or bad reaction to any of the following?

□Aspirin, Codeine	□Acetaminophen/Ibuprofen	□Penicillin	□Erythromycin
□Chlorhexidine (CHX)	□Sulfa	□Local anesthetic	□Fluoride
□Tetracycline	□Iodine	□Metals	□Latex
□Red dye	□Food Allergies: _____		

□Other: _____

FOR WOMEN ONLY: Are you pregnant or breastfeeding? □Yes □No
If pregnant, what is the expected delivery date? _____

To the best of my knowledge, the above information is correct.

Patient/Parent/Guardian Signature: _____Date: _____

Dentist Signature: _____Date: _____

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Dental Questionnaire

Previous Dental History

What is your previous dentist's name and phone number? Name: Phone:
When was the last time you visited a dentist or hygienist? Any x-rays?
Have you been advised to take antibiotics before dental treatment? □ Yes □ No □ Not sure
Is there any history of trauma to your head and/or teeth? □Yes □ No □ Not sure

Current Dental Conditions

Do you have any dental concerns? Any pain or sensitivity in your mouth?
Do your gums bleed or hurt? Any sore spots? □ Yes □ No □ Not sure
Do you feel that you have bad breath on a regular basis? □ Yes □No □ Not sure
Does food get caught between your teeth? Any specific area? □ Yes □No □ Not sure
Do you have any missing teeth? Are you considering any replacement?

Dental habits

Do you ever have any pain in your jaw, ear or side of your face? □ Yes □ No □ Not sure
Do you clench or grind at night? □ Yes □ No □ Not sure
Have you ever worn any appliances (ex: nightguard, retainer) in your mouth? □ Yes □ No □ Not sure
What do you use to clean your teeth? (ex: electric/manual toothbrush/floss/waterflosser) and how often?

Signature: _____ *Date*: _____

Patient or Parent / Guardian