Dr. Edmond Ghiabi
Periodontist

590 North River Road
Suite 1
Charlottetown, PE
C1E 1K1

tel. **902 894.5100**
fax. **902 894.5412**
peiperiodontist.ca

PATIENT REGISTRATION FORM

Patient name ____________________ Date of birth (d/m/y) ____________________

Mailing address ____

____

Phone # ____________________ Email ____________________

☐home ☐mobile

Emergency contact name & phone # ____

Name of person responsible for account ____

Health card #____________________ Expiry date (d/m/y) ____________________

Primary Insurance Coverage

Do you have dental insurance? ☐yes ☐no

Insurance company____________________ Employer____________________

Policyholder name____________________ Policyholder DOB (d/m/y)____________________

Group/Contract/Policy#____________________ Employee #____________________

Secondary Insurance Coverage

Do you have secondary dental insurance? ☐yes ☐no

Insurance company____________________ Employer____________________

Policyholder name____________________ Policyholder DOB (d/m/y)____________________

Group/Contract/Policy#____________________ Employee #____________________

How did you hear about us? ☐My dentist ☐Internet ☐Other ____________________

Patient's (or Guardian's) Signature: ____________________

Date: ____________________

MEDICAL HISTORY FORM

PLEASE ANSWER THE FOLLOWING QUESTIONS ACCURATELY. YOUR RESPONSES WILL REMAIN STRICTLY CONFIDENTIAL.				
			Yes	**No**
1.	Are you under the care of a physician for any medical conditions?			
2.	Have you had an annual check-up within the past 12 months?			
3.	Physician's name ______________________________ Physician's phone number ______________________________			
4.	Have you been hospitalized in the past 2 years?			
5.	Are you currently taking any medications prescribed by your physician? If yes, please list them below: ______________________________ ______________________________ ______________________________			
6.	Are you allergic to any of these medications?	○ Penicillin ○ Sulfa drugs ○ Codeine ○ Aspirin ○ Iodine ○ Local anesthetics ○ Other: ____________________		
7.	Have you experienced excessive bleeding or bruising from a cut before?			
8.	Do you smoke? If yes, how much and for how long? ____________________			
9.	Do you use recreational drugs? If yes, how often and for how long? ____________________			

10.	Do you have any of the following conditions?	Yes	No		Yes	No
	AIDS			High blood pressure		
	Anemia			Jaundice		
	Angina pectoris			Kidney disease		
	Arthritis			Liver disease		
	Artificial heart valves			Malignant hyperthermia		
	Artificial joints (hip/knee)			Mental disorders (specify) ______________________		
	Asthma					
	Bronchitis			Mitral valve prolapse		
	Cancer (specify) ______________________			Organ transplant (specify) ______________________		
	Diabetes (specify) ______________________			Radiation/ chemotherapy		
	Emphysema/bronchitis			Rheumatic/scarlet fever		
	Epilepsy/ seizures			Sickle cell disease		
	Glaucoma			Sinus trouble		
	Heart disease/ attack			Stomach/ intestinal problems		
	Heart murmur			Stroke		
	Heart pacemaker			Thyroid disease (specify) ______________________		
	Heart surgery			Tuberculosis		
	Hepatitis (A, B, or C)			Venereal disease		
	Herpes			Other: ________________		
11.	Is there anything else about your health we need to know? ____					
	WOMEN ONLY					
12.	Are you taking birth control pills?					
13.	Are you pregnant? If yes, how far along? ____					

DENTAL HISTORY FORM

		Yes	No
1.	How frequently do you see a dentist? ☐Annually ☐Bi-annually ☐Emergency care only ☐Other ___________		
2.	When was your last dental visit? _______________ last cleaning? _____________________		
3.	Have you ever seen a periodontist before? If yes, when and for what reason? _________________________________		
4.	Do you brush your teeth at least twice a day?		
5.	Do you floss your teeth at least once a day?		
6.	Do you use any other devices to clean your teeth?		
7.	Are your teeth sensitive to cold?		
8.	Do you have a history of gum disease?		
9.	Do you have a family history of gum disease?		
10.	Do your gums bleed when brushing or flossing your teeth?		
11.	Do you have bad breath or bad taste in your mouth?		
12.	Do your jaws crack or pop when you open or close your mouth?		
13.	Do you grind or clench your teeth?		
14.	Do you have any loose teeth?		
15.	Have you ever had a reaction to local anesthetics (freezing)?		
16.	Have you ever had excessive bleeding during or after a tooth extraction?		
17.	Are you usually anxious before or during a dental visit? If yes, please rate your anxiety: 0 1 2 3 4 5 6 7 8 9 10 (not anxious ……… extremely anxious)		

I consent to dental examination by Dr. Edmond Ghiabi, who may request more x-rays &/or diagnostic models to make accurate diagnosis of my condition and to plan for my treatment.

Patient's (or Guardian's) Name: _________________________________

Patient's (or Guardian's) Signature: _________________________________

Date: _________________________________