DR. EDMOND GHIABI
PERIODONTIST

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PATIENT REGISTRATION FORM

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

Mailing address _____

_____

Phone # _____ Email _____

☐Home ☐Mobile

How would you like to be contacted if necessary: ☐Phone ☐Email

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 (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 _____ Pharmacy'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 the following?	○ Penicillin ○ Sulfa drugs ○ Codeine ○ Aspirin ○ Iodine ○ Latex ○ Other: _____	
7.	Have you experienced excessive bleeding or bruising from a cut or past surgery before?		
8.	Do you smoke cigarettes/cigars? If yes, how much and for how long? _____		
9.	Do you use recreational drugs? If yes, how often? _____		

10.	Do you have any of the following conditions?	**Yes**	**No**		**Yes**	**No**
	AIDS/ HIV infection			High blood pressure		
	Anemia			HIV infection		
	Angina pectoris			Jaundice		
	Arthritis			Kidney disease		
	Artificial heart valves			Liver disease		
	Artificial joints (hip/knee)			Malignant hyperthermia		
	Asthma			Mental disorders (specify) _____		
	Bronchitis					
	Cancer (specify) _____			Mitral valve prolapse		
	Diabetes (specify) _____			Organ transplant (specify) _____		
	Emphysema			Radiation/ chemotherapy		
	Epilepsy/ seizure			Rheumatic/scarlet fever		
	Glaucoma			Sickle cell disease		
	Heart attack			Sinus trouble		
	Heart disease			Stomach/ intestinal problem		
	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

1.	How frequently do you see a dentist? ☐Annually ☐Bi-annually ☐Emergency care only ☐Other _____		
2.	When was your last dental visit? _____ Last cleaning? _____		
		Yes	No
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 and x-rays &/or diagnostic models, if needed. I understand that a portion of this information may have to be shared with my physician, dentist &/or insurance company.

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

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

Date: _____