Dr. Edward S. Philips Dr. Paul N. Custoreri
Dr. Robert T. Feeley Dr. Arick Faibish Dental Surgeons
Dr. Alan Ghent Periodontist

All information is confidential and will remain with this office. The dental administration staff is available to help you complete any portion of this form. Full completion of the forms will allow us to provide you with the highest standard of dental care. Thank you for your co-operation.

REGISTRATION INFORMATION

NAME:_____Dr. / Mr. / Mrs. / Ms. / Miss

Date of Birth:_____ Age:_____

ADDRESS:_____
(Street) (Apt/Unit#) (City) (Prov) (Postal Code)

Home Phone: ( )_____ E-Mail: _____

Bus. Phone: ( )_____ Ext_____ Employer:_____

Cell Number: ( )_____ OHIP#: _____

Whom may we thank for referring you to our practice? _____

How did you hear about us? _____

Do you have a specific need? If yes, please describe: _____

How often do you see the dentist? _____

When was your last dental visit?_____What was done?_____

When was the last time you had any dental x-ray taken?_____

How often do you brush?_____ How often do you Floss?_____

Do your gums ever bleed, are they swollen or painful?_____ YES NO

Do you ever have jaw joint pain? _____ YES NO

Do you ever clench or grind your teeth? _____ YES NO

Do you ever bite your cheek or lip? _____ YES NO

Are you aware of any swelling, sore spots or lump(s) in your mouth? _____ YES NO

Have you ever had any traumatic injury to your face? _____ YES NO

Have you ever noticed any loose teeth or have any of your teeth shifted?_____ YES NO

Does food catch between your teeth? _____ YES NO

Have you been advised to take antibiotics before a dental appointment? _____ YES NO

Do you smoke? If so, how much? _____ YES NO

Are you wearing the transdermal nicotine patch? _____ YES NO

Do you drink? If so, how much? _____ _____ YES NO

Do any of your teeth hurt/ache (e.g. sensitive to sweet, cold, hot, pressure)?_____ YES NO

Please describe: _____

Have you had any kind of oral surgery? _____YES NO

Doctor who performed oral surgery:_____ Phone ( )_____

Have you ever had Orthodontics (Braces)?_____YES NO

Doctor's Name:_____ Phone ( )_____ Date of last exam: _____

Do you have or have had any of the following? Please indicate by circling:

heart problems / surgery	diabetes	strep throat
pacemaker	kidney problems	tonsillitis
chest pain	hepatitis / liver problems	tuberculosis
excessive bleeding	rheumatic / scarlet fever	transmittable diseases
fainting / dizziness	epilepsy / seizures	venereal disease, herpes
blood disorders	measles / mumps / chicken pox	HIV / AIDS
high / low blood pressure	thyroid disease	contagious diseases
anemia	ulcers / stomach problems	anxiety problems
sinus problems	stroke / paralysis	psychiatric problems
asthma / emphysema	arthritis / gout	steroid therapy
lung / breathing problems	circulation problems	cancer / tumors
surgery in hospital	artificial joints (e.g. hip, knee)	radiation or chemotherapy
organ transplant /medical implant	pregnancy (months?____)	

Allergies:_____

Please indicate any other medical conditions that we have not mentioned above: _____

_____

Please indicate any PRESCRIPTION or NON-PRESCRIPTION medications, pills or drugs which you are taking: _____

Do you have FREQUENT, SEVERE headaches, earaches, ear/throat infections?_____

Do you have any other questions or concerns?_____

Any other family members patients at our office?(please list)_____

Do you have Dental Insurance?_____ Name of policy holder?:_____

Employer of individual subscriber:_____ Date of Birth of policy holder: _____
M/ D/ Y

Name of insurance Company:_____

Group/Policy #_____ Certificate/ID#_____

Is there Secondary/Co- insurance? If yes, Name of policy holder?:_____

Employer of individual subscriber:_____ Date of Birth of policy holder: _____
M/ D/ Y

Name of insurance Company:_____

Group/Policy #_____ Certificate/ID#_____

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in my health status in the future, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another healthcare provider may be necessary, and I consent to the release of this information. I authorize release, to my insurance company/plan administrator, the information contained in claims electronically and for direct assignment to the dental office, if applicable. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services**.**

Please Note: A potential fee of $50 may be charged for any missed/rescheduled appointments without 2 full business day's notification.

X_____

(Signature) Patient ___ Parent___ Guardian___ (print name of guardian)

Date:_____ Reviewed by Treating Dentist: _____