



onesmile

Dentistry • Dental Hygiene • Orthodontics

Teeth Cleaning Laser Teeth Whitening-Zoom
Braces 6 month smile Extractions | Implants | Fillings

Reviewed by _____

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Patient Registration Form

Mr Mrs Ms Miss/Master First Name _____ Last Name _____
Date of Birth: _____ Gender: Male _____ Female _____
Address: _____ City: _____ Postal Code: _____
Home Tel: _____ Work _____ ext _____ Cell _____
E-mail address: _____

I consent to receiving electronic communications for **ONESMILE** such as appointment confirmations, newsletter, and special offers. I can opt out of this at any time.

Best Time To Contact You: Morning _____ Afternoon _____ Evening _____
Best Method To Reach You: E-mail _____ Home # _____ Cell # _____

How did you hear about us?

A friend or family member named _____
 Internet Search Flyer Ad Yellow Pages Sign Other _____

Emergency Contact: In case of an emergency, who should we call?

Name: _____ Relationship to you: _____
Home Tel #: _____ Work Tel #: _____ Cell #: _____

Financial Responsibility: If you are under the age of 18, please indicate the following:

I am responsible for my account - OR - The following person is responsible for my account:
Name: _____ Relationship to you: _____
Address: _____ City: _____ Postal Code: _____
Telephone numbers: Home _____ Work _____ ext _____ Cell _____

Insurance Coverage

Primary Insurance

Name Of Insured: _____
Male _____ Female _____ Date Of Birth: _____
Employer: _____
Insurance Company: _____
Group/ Plan/ Policy #: _____
ID / Certificate #: _____

Secondary Insurance

Name Of Insured: _____
Male _____ Female _____ Date Of Birth: _____
Employer: _____
Insurance Company: _____
Group/ Plan/ Policy #: _____
ID / Certificate #: _____

Appointment Cancellations

Cancellation Charges: I understand that when an appointment is booked for me, the staff time is reserved for me. The equipment and materials are set up for me. If I need to change or cancel an appointment, I will provide 2 business day's notice (except in emergency situations). I understand that without 2 business day's notice, a charge may be applied. The amount charged will depend on the length of the appointment.

Initial To Signify That You Understand This Policy: _____

Medical History:

Do you currently have, (or within the last 6 months, had) any of the following?

- | | | |
|---|----------------------------------|--|
| <input type="checkbox"/> AIDS/ HIV | Head Injuries | Pacemaker |
| <input type="checkbox"/> Allergic to _____ | Heart Disease | Radiation Treatment |
| <input type="checkbox"/> Anemia | Heart Murmur | Respiratory Problems |
| <input type="checkbox"/> Angina Pectoris | Heart Rhythm disorder | <input type="checkbox"/> Rheumatic Fever (Scarlet Fever) |
| <input type="checkbox"/> Arthritis | Heart Surgery | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Heart Valve | Hepatitis A B C _____ | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Artificial Joints | High Cholesterol | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Asthma | Hyper/hypo Glycemia | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Blood Disorder: _____ | Inflammatory bowel disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cancer | Migraines | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulation problems | Blood Pressure High Low | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Congenital Heart Lesions | Jaundice | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Crohn's Disease | Kidney Disease | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Type II | Liver Disease | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | Lung Disease | |
| <input type="checkbox"/> Emphysema | Lupus | Usual Blood Pressure: _____/_____
(if known) |
| <input type="checkbox"/> Epilepsy | Malignant Hyperthermia | For Women: Are you currently
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Excessive Bleeding | Mental Disorder | Due Date: _____ |
| <input type="checkbox"/> Fainting | Nervous System Disorder | |
| <input type="checkbox"/> Glandular disorders | Organ Transplant/Medical Implant | |
| <input type="checkbox"/> Glaucoma | | |

Are you under the care of a Medical Specialist? Y N Type _____ Name _____

Medications - Please List Your Regular Medications Below:

Dental History & Concerns: Mark the areas that apply, and if desired, use the lines to provide additional details.

When was your last dental visit? _____ Name of dentist _____

What did you like about your previous dental office? _____

Anything you disliked about your previous dental office? _____

Do you need sedation to make your visits comfortable? _____

Do your gums bleed at all when you brush your teeth? _____

Do you experience a bad taste or odour in your mouth? _____

Do you feel your gums are shrinking, or your teeth are getting longer? _____

Are any of your teeth sensitive to hot or cold? _____

Are any of your teeth sore to chew on? _____

Does your jaw click or crack or pop? _____

Do you want whiter teeth? _____

What are your goals for your visit today? _____

Do you have any other dental or oral health goals you want to discuss with us? _____

Sign below to confirm that all the information on this registration form is accurate to the best of your knowledge

Patient Signature: _____ Date _____