Harbourside
Oral & Facial Surgical Centre

PATIENT REGISTRATION & MEDICAL HISTORY

The data on this confidential questionnaire is essential to render the best professional care. Please fill out the answers carefully. If you have any questions, please ask.

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH M D Y
ADDRESS		CITY	POSTAL CODE
HOME PHONE (AREA CODE)		BUSINESS PHONE (AREA CODE)	
SEX	HEIGHT / WEIGHT	OCCUPATION	
IF MARRIED, SPOUSE'S NAME		IF CHILD, PARENT'S NAME	
PERSONAL HEALTH # (CARE CARD)			

PRIMARY DENTAL INSURANCE		SECONDARY DENTAL INSURANCE	
NAME OF INSURED	DATE OF BIRTH M D Y	NAME OF INSURED	DATE OF BIRTH M D Y
EMPLOYER		EMPLOYER	
INSURANCE CARRIER		INSURANCE CARRIER	
GROUP/POLICY NUMBER		GROUP/POLICY NUMBER	
I.D. # OR S.I.N. OR CERTIFICATE #		I.D. # OR S.I.N. OR CERTIFICATE #	

MEDICAL HISTORY

General Health (please check): ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Name and address of physician: _____

Date of last complete physical or doctor's visit: _____

Have you ever had any serious illness or operation? ☐ YES ☐ NO If yes, what? _____

Are you taking any medication now? (birth control?) ☐ YES ☐ NO Please list: _____

Do you smoke? ☐ YES ☐ NO Approx. No. per day _____

Please check the box if you have ever had or been treated for:

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Disease or Condition	☐	☐	Asthma	☐	☐	Jaundice or Hepatitis A ☐ B ☐ C ☐
☐	☐	Rheumatic Fever or Heart Murmur	☐	☐	Bleeding Disorders	☐	☐	Blood Borne/Infectious Diseases
☐	☐	Abnormal Blood Pressure	☐	☐	Anemia	☐	☐	Psychiatric Illness (Depression, etc.)
☐	☐	Stroke	☐	☐	Arthritis	☐		Other _____
☐	☐	Epilepsy or Seizures	☐	☐	Glaucoma			_____
☐	☐	Diabetes	☐	☐	Kidney / Bladder Problems			_____
☐	☐	Lung Disease or Tuberculosis	☐	☐	Ulcers or Intestinal Conditions			_____

In the last 2 years, have you ever been treated with cortisone, steroids or blood thinners? ☐ YES ☐ NO

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local Injected Anesthetics ☐ Other _____

Are you subject to fainting spells? ☐ YES ☐ NO Are you pregnant? ☐ YES ☐ NO approx. how long? _____

Is there anything else concerning your health that you think the doctor should know about? ☐ NO ☐ YES _____

First day of menstrual period _____

Signature _____ Date _____ Parent/Guardian _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____