SOUTH CALGARY ENDODONTICS

Patient Registration

PATIENT INFORMATION

Mr. Mrs. Ms. Dr.	First Name		MI		Last Name	
Birth Date		Alberta Health Care #			Email	
Address		City		Prov		Postal Code	
Home Phone		Cell Phone		Work Phone		
Preferred Method of Contact:	❑ Call	❑ Text	❑ Email			
Referring Dentist		Phone				
If patient is a minor, who is legally responsible?						
Do you have Dental Coverage?	❑ Yes	❑ No				

EMERGENCY CONTACT

First Name		Last Name	
Telephone		Relationship to Patient	

HEALTH HISTORY

Are you presently being treated by a physician?	❑ Yes	❑ No			
Family Physician		Last Physical Exam			
Are you currently taking any medications?	❑ Yes	❑ No			
If yes, please list					
Do you have any medication or environmental allergies or allergic reactions?	❑ Yes	❑ No			
If yes, please list					

Do you now have, or have you ever had, any of the following?

	Yes	No		Yes	No		Yes	No
Heart Disease/ Murmur/ Angina			Thyroid Condition			Bone Disorder/ Osteoporosis		
Pacemaker			Adrenal Gland Issues			Stroke/ Transient Ischemic Shock		
Swollen Ankles			Diabetes			Cancer		
High Blood Pressure			Seizures/ Epilepsy			Type		
Low Blood Pressure			Neurological Condition			Radiation		
High Cholesterol			Sinus Problems			Chemotherapy		
Kidney Disease/ Bladder Issues			Hearing Loss/ Ear Condition			Steroid Therapy		
Stomach Issues/ Ulcer			Headaches/ Migraines			Lung Condition		
Reflux Issues			Psychiatric Care			Asthma/ Cough		
Ulcerative Colitis			Depression			Arthritis/ Muscle Weakness		
Anemia			Anxiety			Joint Replacement		
Liver Disease			Eating Disorder			Alcohol Dependency		
Hepatitis			HIV/ AIDS			Malignant Hyperthermia		

Is there any disease, condition, or problem that you think our office should know about that is not listed above?	❑ Yes	❑ No

Please explain/clarify any conditions selected above along with any other condition not listed.

Females Only

Are you pregnant? *Please inform our office if you become pregnant during the course of treatment.*	❑ Yes	❑ No

FORM COMPLETION

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the dentist of any changes in my health or medication.

Signature of Patient, Parent or Guardian:		Date:	

IF PATIENT IS A MINOR

Form signed by:		Relationship to Patient:	