elements
DENTAL

PATIENT REGISTRATION ALL INFORMATION IS CONFIDENTIAL

PLEASE PRINT

Date _____ (M D Y)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other _____

Name: _____ (last) (first) (initial)

Address: _____ (street) (city) (province) (postal code)

Date of Birth _____ (M D Y) Age _____ Sex _____ Provincial Health No. _____

Occupation / Employer _____ Work Telephone No. _____

Home Telephone No. _____ Cell Telephone No. _____ Email _____

Person responsible for account: ☐ Self ☐ Spouse ☐ Other If other, please complete the following:

Name _____ Telephone No. _____

Address _____ (street) (city) (province)

Family Physician _____ Telephone No. _____

Medical Specialist _____ Telephone No. _____

Do you have dental insurance? ☐ Yes ☐ No

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
NAME OF INSURED	NAME OF INSURED
DATE OF BIRTH (M D Y)	DATE OF BIRTH (M D Y)
EMPLOYER	EMPLOYER
INSURANCE COMPANY	INSURANCE COMPANY
GROUP/POLICY NO.	GROUP/POLICY NO.
DIVISION	DIVISION
I.D. NUMBER.	I.D. NUMBER
CERTIFICATE NO.	CERTIFICATE NO.
DEP. NO.	DEP. NO.
COVERAGE PERCENTAGE	COVERAGE PERCENTAGE
A B C D	A B C D
LIMITS	LIMITS
BASIC MAJOR ORTHO	BASIC MAJOR ORTHO
DEDUCTIBLE	DEDUCTIBLE
☐ PER PERSON	☐ PER PERSON
BASIC MAJOR	BASIC MAJOR
☐ PER FAMILY	☐ PER FAMILY

In case of emergency, please notify: _____ Telephone No. _____

Relationship: _____ Telephone No. _____

Is another member of your family or relative a patient at our office? _____

Whom may we thank for referring you? _____

PLEASE TURN OVER ☛

Patient Registration Form

Guarantees

Dentistry is not an exact science; there are many unforeseen variables, thus, planned treatment results are not always attainable, risks may be involved regardless of the expertise of the dentist. We do stand behind our work, and we will make every reasonable effort to be fair. Our goal is to provide quality dentistry for our patients.

We will not be held responsible for unsatisfactory treatment results caused or contributed by a patient's failure to take reasonable care or to follow our advice. If instructions in a given situation are unclear, we encourage you to ask questions.

Respectful Behaviour Policy

At our practice, we are committed to creating a safe, inclusive, and respectful environment for all patients, families, and staff. We ask that all individuals treat one another with courtesy and kindness, regardless of background, identity, or circumstance. Disrespectful, aggressive, or discriminatory language or behaviour will not be tolerated and may result in the rescheduling or cancellation of appointments. We appreciate your partnership in helping us maintain a welcoming space for everyone.

Appointment Cancellation Policy

We understand that schedules can change. If you need to cancel or reschedule your appointment, we kindly ask that you provide at least 24 hours' notice. This allows us to offer your appointment time to another patient. Cancellations with less than 24 hours' notice, or missed appointments without notice, may be subject to a fee.

Medication and Substance Disclosure

For your safety, it is essential that you inform us of all medications, supplements, and substances you have taken prior to your appointment, including alcohol, cannabis, and other prescription or street drugs. Some substances can affect the safety and effectiveness of dental treatments or procedures. Full disclosure helps us provide you with the best and safest care possible. If you arrive under the influence of substances that may impair your judgment or ability to receive treatment safely, we may need to reschedule your appointment.

We ask that you refrain from wearing perfume or other fragrances to the clinic. These odors may trigger asthma, rhinitis or migraines for some of our patients.

Dental Plans & Payments

Co-payments, co-insurance and deductibles are due at the time of your visit. If arrangements need to be made depending on your insurance coverage or if there are special circumstances, please see the front desk to make those arrangements prior to your appointment otherwise a **$50 late payment administration fee will apply.**

Insurance & Fees

Dental insurance coverage varies by carrier, plan, and procedure, so it's your responsibility to understand your policy's terms and exclusions. While we submit claims and quote estimates on your behalf, these are estimates only — actual coverage depends on the details you've provided and may be affected by annual limits, non-covered procedures, and other plan-specific factors (e.g., fee differences between amalgam and composite fillings, sealants, etc.).

We accept direct payment from your insurer if your plan allows assignment of benefits to our office. If your insurer delays or fails to pay, the outstanding balance becomes your responsibility, and we'll direct future payments to you unless other arrangements were made before treatment.

Patient Certification & Consent

I certify that the medical and dental information I've provided is true and complete to the best of my knowledge, and I consent to my physician being contacted if needed for my dental care.

Elements Clinic uses AI-assisted note-taking to record conversations with staff and patients, supporting our documentation and treatment planning. I consent to voice recordings for this purpose.

*I **do not** consent to voice recordings for note-taking — check here:* ☐

I consent to the dental and oral surgery procedures agreed upon with your office, including the use of local anaesthetic as indicated, and I accept responsibility for all associated fees and any interest on unpaid balances (18% per annum / 1.5% per month).

I have read and understand the above and agree to these conditions. I understand that either party may choose to end the patient-dentist relationship if these conditions are not upheld.

Patient (Parent,Guardian*) Signature:_____ Date: _____

Patient name (Parent, Guardian*): _____

*Guardian of Child or Guardian of Adult under Guardianship

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox ____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]_____ ☐ ☐
2. Have you had an unfavorable dental experience?_____ ☐ ☐
3. Have you ever had complications from past dental treatment?_____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?_____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?_____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?_____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?_____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?_____ ☐ ☐
20. Do you frequently get food caught between any teeth?_____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your back teeth together?_____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?_____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?__ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?_____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore?_____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?___ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?_____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____