DR. JOHN L. CHIASSON DENTISTRY

REGISTRATION

Please complete this form to the best of your ability. The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality.

NAME First:____________________Last:____________________Initial:____ Date of Birth: (dd/mm/yr):___/___/___

Address: Street____________________ City/ Prov:____________________Postal Code:______________

Cell:____________________ Home / Work:____________________Email: ____________________

Preferred Method of Contact: ___Phone ___ Text ___ Email Preferred Appointments time: am / pm / evening

Are you available for short notice appointments? ___ Yes ___ No How did you hear about us?____________________

Emergency Contact: Name:____________________Relationship to Patient:_________ Phone

MEDICAL HISTORY

Doctor: Name:____________________Phone:______________ **Pharmacy /Location:**:____________________

1. Are you being treated for any medical condition at present or have within the past two years? ☐ Yes ☐ No
   If so, why?____
2. Have you been hospitalized within the past 2 years? ☐ Yes ☐ No
   If yes, please explain____
3. Do you take any Medications or Non Prescribed Drugs? ☐ Yes ☐ No
   If yes, please list ____
4. Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ Yes ☐ No
5. Are you immune compromised? If yes, explain______________________________ ☐ Yes ☐ No
6. Do you have high or low blood pressure? If yes? which ______________________ ☐ Yes ☐ No
   Do you take blood thinner medication? (If yes, ensure that it is included in your list of medications.) ☐ Yes ☐ No
7. Do you have a blood clotting condition? If yes, explain______________________________ ☐ Yes ☐ No
8. Have you ever been advised by your doctor to change the doseage or stop taking a medication prior to dental treatment? If yes, please explain______________________________ ☐ Yes ☐ No
9. Do you use controlled substance , cannibis or tabacco? ☐ Yes ☐ No

ALLERGIES...(check where applicable) __Aspirin __ Latex __ Codeine __ Anaesthetic __Other (specify) ______________
____

Do have or had a history of any of the following? (Please check all that apply)

☐ AIDS or HIV Positive	☐ Chemotherapy	☐ Hepatitis	☐ Paget's Disease
☐ Anaphylaxis	☐ Chronic Cough	☐ Heart Surgery	☐ Psychiatric
☐ Anemia	☐ Cold Sores / Blisters	☐ Heart Murmer	☐ Treatment Rashes / Hives
☐ Angina / Chest Pain	☐ Cortisone Medication	☐ Heart Attack	☐ Radiation
☐ Arteriosclerosis	☐ Diabetes	☐ Pacemaker	☐ Rhumatic Fever
☐ Artifical joints (hip or knee)	☐ Drug / Alcohol Addiction	☐ Heart Disease	☐ Sinus Trouble
☐ Arthritus	☐ Excessive Bleeding	☐ Hemophilia	☐ Stomach / Intestinal Disease
☐ Asthma	☐ Epilepsy / Seizure Disorder	☐ Hypoglycemia	☐ Stroke
☐ Blood Transfusion	☐ Fainting / Dizzy Spills	☐ Liver Disease	☐ Swelling of Limbs
☐ Shortness of Breath	☐ Frequent Headaches	☐ Kidney Disease	☐ Thyroid Disease
☐ Bruises Easily	☐ Genital Herpes	☐ Malignant Hyperthermia	☐ Tuberculosis (TB)
☐ Cancer	☐ Hearing Impaired	☐ Prosthetic Heart Valve	☐ Tumors / Growths / Ulcers

Have you ever had any serious illness or disease not listed above? If yes, explain______________________________

For Women Only: Are you currently breast feeding or pregnant? __Yes __ No If pregnant, what is your due date? __________

CONSENT FOR TREATMENT: I the undersigned, certify that I have provided an accurate and complete medical and dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment.

Signature______________________________ **Date**____________________

DENTAL HISTORY

Please circle Yes or No, where applicable.

PATIENT: ____________________________

Are you in pain or currently experiencing any oral discomfort? ☐ Yes ☐ No If yes, explain___________________________

When was your last?

Dental visit: ____________ Hygiene Visit (Cleaning): _________ Dental x-rays: __________ Panoramic x-ray: ________

How many times a year do you? Visit the dentist: ________________ Have Professional Cleaning(s): _____________

Do you have:

- Tooth sensitivity to heat, cold, sweets or pressure? ☐ Yes ☐ No
- Pain or swelling of the gums? ☐ Yes ☐ No
- Bad breath? ☐ Yes ☐ No
- Growth or sores in your mouth? ☐ Yes ☐ No

Have you ever had any of the following:

- Periodontal treatment (treatment of gums)? ☐ Yes ☐ No
- Oral surgery (extractions, broken jaw)? ☐ Yes ☐ No
- Orthodontic Treatment (braces, retainers, appliance to teeth)? ☐ Yes ☐ No
- Dental work done while asleep or sedated while in a dental office or hospital? ☐ Yes ☐ No
- Dental work done using freezing and or nitrous gas? ☐ Yes ☐ No

How often do you brush you teeth in a day? ____________________________

What time(s) of the day? AM PM

Do you use an electric toothbrush? ☐ Yes ☐ No

Does you use floss / proxabrush / stimulants to clean your teeth? ☐ Yes ☐No, If yes how often?___________

Do / Does you(r):

- Suffer from heaches? ☐ Yes ☐ No
- Clench or grind your teeth? ☐ Yes ☐ No
- Experience popping / clicking of jaw joints? ☐ Yes ☐ No
- Have pain in your jaw joints and / or near your ear and side of face? ☐ Yes ☐ No
- Have pain when opening and closing your jaw? ☐ Yes ☐ No
- Your jaw lock when open or closed? ☐ Yes ☐ No

Does having dental treatments make you nervous or uncomfortable? ☐ Yes ☐ No

Have you ever had an upsetting experience in a dental office, or any complications during or following treament? ☐ Yes ☐ No

If yes, explain:____

Do you feel it is important for you to keep your natural teeth? ☐ Yes ☐ No

Would you like to see any cosmetic changes? ☐ Yes ☐ No If yes, explain:_______________________________

To my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dentist of any changes in medical.

Signature Of Patient, Parent Or Guardian _________________________________ **Date**_____________________

FINANCIAL AGREEMENT: CASH I PERSONAL HEALTH SPENDING ACCOUNTS (PHSP'S)

PATIENT:___________________________

As a condition of your or your child's treatment by this office, financial arrangements must be made prior to treatment; this includes dental emergencies . **PAYMENT IS DUE IN FULL AT TIME OF APPOINTMENT,** unless an alternative financial agreement has been made. We accept Cash, Visa, Mastercard, and Debit. Personal cheques will not be accepted. Please note that individuals who have a Personal Health Spending Account (PHSP) are required to submit dental claims to their insurance company directly.

CANCELLATION POLICY

We try our very best to offer you appointments that accomodate your schedule. This time is reserved just for you, and has been scheduled by you. In order to give you the best care possible and to be fair to all our patients and team, we ask that you make every effort to keep these appointments. If you are unable to keep your appointment, we ask that you provide us at least two business days notifice. Short Notice Cancellations and Missed Appointments may result in a $50 service fee. As a courtesy, automated text and email reminders are sent prior to appointments. We ask that you please confirm your appointment by responsding to the text / email, or calling the office. Your dental appointment is confirmed until we receive a verbal cancellation.

CONSENT

In accordance to the Federal and Provincial Privacy Legistation we will not disclose personal information and / or xray(s). However at times we do need to use the information for the following purposes: assess dental treatment,specialist referrals, appointment confirmations, account management, insurance purposes, and comply to requlatory reguirements.

I HAVE READ THE ABOVE CONDITIONS PERTAINING TO PAYMENT AND INSURANCE, CANCELLATIONS, AND AGREE TO THEIR CONTENT.

Patient / Responsible Party (Signature):________________________ Date:_________________________

DENTAL RECORDS RELEASE FORM

Patient Name to Transfer: ______________________________

Date of Birth: ______________ Phone Number: ______________

Other Family Members to Transfer:

1. ______________ 2. ______________

3. ______________ 4. ______________

Previous Dentist or Dental Practice Name: ______________________________

City: ______________________________

Phone Nunber: ______________ Fax: ______________

E-Mail: ______________________________

Please forward the following information that you have: x-rays, probing depth chart, charting and photographs to **Dr. John L. Chiasson**.

Last Complete Exam:

Last Recall / Polish / Flouride: Frequency:

Last Cleaning : Frequency:

Last BW's / Panoramic:

I hereby give you permission to release any and all dental records to **Dr. John L. Chiasson**

______________________________ ______________

Patient's Signature (guardian if minor) Date

Dr. John L. Chiasson Dentistry

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