Dr. Erin J. Shave Inc.

REGISTRATION FORM - (PLEASE PRINT AND COMPLETE FULLY)

PATIENT INFORMATION

Patient's last name:	First:	Middle initial:	❑ Mr. ❑ Mst ❑ Dr.	❑ Miss ❑ Ms. ❑ Mrs

Is this your legal name? ❑ Yes ❑ No	Personal Health Care #	Birth date: MM / DD / YR	Age:	Sex: ❑ M ❑ F

Apt /Street address:	City & Province	Postal code:

Home #	Work #	Cell #	Email Address

Occupation:	Employer:

Referred to clinic by (please check one box):	❑ Family/friend ❑ Website ❑ Family Dentist ❑ Other : _____

Name of referral:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Are you covered with dental insurance? ❑ Yes ❑ No Do you have dual insurance? ❑ Yes ❑ No

Name of Primary insurance (if applicable):	Subscriber's name and birthdate:	Group no.:	ID or sin# no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	Dep. #

Name of Secondary insurance (if applicable):	Subscriber's name and birthdate	Group no.:	ID or sin# no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	Dep. #

IN CASE OF EMERGENCY

Name of next of kin or friend:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I certify that I have read and understand the above information to the best of my knowledge. The above questions and the health questionnaire have been accurately answered. I understand that providing incorrect information cans be dangerous to my health. I authorize the dentist too release any information including the diagnosis and the records of any treatment or examination rendered to me/or my child during the period of such dental care to third party payors and/or Health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am financially responsible to my dentist for the entire treatment rendered on my behalf or my dependents.

_____ _____

Patient/Guardian signature *Date*

COMPLETE OTHER SIDE PLEASE

HEALTH QUESTIONNAIRE

To help ensure your well being while receiving treatment in our office, please answer the following questions.
All information will be considered confidential and for our records only. I certify the above information is correct to the best of knowledge.

Last name:_____**First name:**_____**Middle initial:**_____**DOB:**_____

1. **Have you been examined and /or treated by a physician within the last year? YES NO ~ if yes, When?** _____
   Physician's Name:_____**Physician's Phone:**_____
2. **Have you ever been seriously ill or hospitalized? YES NO *If yes When?** _____
3. **Do you require any antibiotic coverage before any dental treatment? YES NO**
4. **Are you on blood thinners? YES NO** ***if YES the medication you are taking*:**_____

Please check (√) if you have ever had any of the following: * **Reviewed by:**_____

⊡ Angina - Chest pain		**SENSITIVITIES/ALLERGIES:**
⊡ Arthritis	⊡ Inflammatory rheumatism	⊡ Aspirin
⊡ Artificial Joints (hip/knee)	⊡ Lung/breathing problems	⊡ Codeine
⊡ Asthma	⊡ Mitral Valve Prolapse	⊡ Penicillin (Antibiotics)
⊡ Blood pressure problems	⊡ Mental health diagnosis	⊡ Sulfa
(CIRCLE) TYPE: HIGH or LOW	⊡ Transplants i.e.: Hip/Knee	⊡ Tylenol
⊡ Bruise easily	⊡ Pacemaker/artificial valves	⊡ Sulphite
⊡ Cancer	⊡ Prolong bleeding after injury	⊡ Latex
⊡ Radiation/ chemo treatment	⊡ Persistent cough	
⊡ Cold sores	⊡ Painful swollen joints	Woman only:
⊡ Congenital heart condition	⊡ Rheumatic fever	Are you pregnant? Yes No
⊡ Cortisone/steroid therapy	⊡ Recent change in appetite	If so, how many _____ months
⊡ Diabetes	⊡ Severe headaches	
(CIRCLE) TYPE: Type 1 or Type 2	⊡ Sinus trouble/ Sore throats	(CIRCLE) Do you smoke or vape?
⊡ Difficulty swallowing	⊡ Stomach/intestinal problems	(CIRCLE)Tobacco use:Marijuana/chewing
⊡ Earaches	⊡ Tendency to faint	*** **Are you taking any medications?**
⊡ Feel thirsty much of the time	⊡ Trouble hearing	If so please list:
⊡ Frequent indigestion/vomiting	⊡ Tumors or growths	⊡
⊡ Heart Attack or Stroke ~ When?	⊡ Vertigo	⊡
⊡ Heart murmur/ palpitations	Other not listed:	⊡
⊡ Liver disease/ Hepatitis Type:	⊡	⊡
⊡ AIDS or HIV	⊡	⊡

Is there anything else concerning your health not listed that you think the doctor should know about? YES NO

_____

1) When was your last dental visit? _____
2) Have you had regular dental exams in the past? If yes what was done: _____
3) Have you had x-ray taken with in the last year? _____
4) Are you having dental discomfort or dental pain? _____
5) Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma? YES NO
6) I brush _____times a day. I floss _____times a day.
7) Do your gums bleed when brush or floss? NEVER SOMETIMES OFTEN
8) Do you have any oral habits: clenching, grinding, nail biting, thumb sucking? YES NO
9) Have you ever had professional tooth brushing & flossing instructions? YES NO
10) Have you had and problems with or unpleasant reactions to dental treatment? YES NO
11) Are you happy with the appearance of your teeth? YES NO
12) My primary concern is: _____

_____

Date:_____**Signature:**_____

⊡ Patient ⊡ Parent ⊡ Guardian

Updated on:	**Updated on:**	**Updated on:**
Pt's signature	**Pt's signature**	**Pt's signature**