Island Perio

Phone: (250) 383-1331
Fax: (250-383-1337
www.islandperio.com

PATIENT REGISTRATION FORM

(Please print)

PATIENT INFORMATION			
First name: **Last name:**		**Preferred pronoun:** ❑ She/her ❑ He/his ❑ They/their ❑ Other	Birth date: (MON / DD / YYYY) / /
Street address:	City, Province:		Postal Code:
Email address:			
Primary phone #: ( )	Alternate phone #: ( )		
Preferred communication method for appointment reminders:	❑ Phone (primary) ❑ Phone (alternate) ❑ Email		
Family Physician:	**B.C. Care Card #**		
Occupation / Workplace:			
Emergency Contact (name / phone):			

DENTAL HISTORY	
Who is your regular / general dentist? ____________________	
Is there currently pain or discomfort in your mouth?	❑ Yes ❑ No
What is your level of anxiety / stress / fear when going to the dentist?	❑ None ❑ Mild ❑ Mod ❑ Severe
Have you had previous periodontal treatment or surgery?	❑ Yes ❑ No
-What / where / when?	
-Last cleaning & frequency?	
Are your gums:	❑ Swollen ❑ Bleeding ❑ Sore
Are your teeth:	❑ Sensitive ❑ Loose ❑ Sore
Is any extensive treatment (crowns, bridges, dentures) planned by your general dentist? Please describe: ____________________	❑ Yes ❑ No

Please check all that apply:

❑ Tooth grinding or clenching	❑ History of orthodontics (braces)	❑ Sleep apnea
❑ Acid reflux / heartburn / GERD	❑ Family history of early tooth loss	

❑ Oral appliance (Examples: nightguard, retainer, CPAP); **please specify**: ____________________

How do you care for your teeth at home?

❑ Brushing; # times per day: ________ ❑ Floss; frequency ______________ ❑ Water Pik

❑ Electric brush ❑ Manual brush ❑ Interproximal brushes ❑ Mouthrinse: _____________

❑ Other tools / products (please specify):

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MEDICAL HISTORY

1) Please list any serious illnesses, surgeries or infections you may have had:

2) Have you had an adverse reaction to the following or any other drugs or materials: ❑ No

❑ Penicillin ❑ Codeine
❑ Aspirin ❑ Dental Anaesthetic Other ____________________

3) Do you smoke? ❑ Yes ❑ No ❑ Ex-smoker

If yes or a history, how much and for how long? ____________________
If yes, ever tried to quit? ❑ Yes ❑ No
Do you use cannabis products? If so, please specify: ____________________

4) Please specify if you take any of the following:

- **Blood thinners** (eg Coumadin, Plavix etc.): ____________________ (INR if applicable: __________)
- **Daily aspirin** ❑ Yes ❑ No
- **Drugs that affect your bones** (eg for osteoporosis)**:** ____________________
- **Please list any other medications, vitamins or supplements you may take** (additional page may be used):

Name of medication:	What condition you take it for:
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

5) Have you ever been diagnosed with heart disease? ❑ Yes ❑ No

Do you have any of the following risk factors? (check all that apply)
❑ Family history ❑ Elevated cholesterol ❑ High blood pressure

6) Have you ever been diagnosed with diabetes? ❑ Yes ❑ No
If yes, how is your diabetes control? ❑ Good ❑ Fair ❑ Poor

If yes, date and value of your last HbA1c: ____________________

7) Do you have or have you had any other medical conditions?

❑ Asthma / COPD	❑ Thyroid disease	❑ Prosthetic heart valve
❑ Osteoarthritis	❑ Steroid use	❑ Artificial joint
❑ Cancer	❑ Kidney or liver problems	❑ Psychiatric therapy
❑ Chemo or radiation	❑ Hepatitis	❑ Change in health in last year
❑ Epilepsy / seizures	❑ HIV	❑ Any addiction / drug use (past or present)
❑ Rheumatoid arthritis	❑ ***Other not listed / details:***	
❑ Osteoporosis	____________________	
❑ Bleeding problems	____________________	
❑ Immunosuppressed		

8) Women: Are you pregnant now? ❑ Yes ❑ No ❑ Possibly ❑ Recently gave birth ❑ Nursing

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FINANCIAL & INSURANCE (IF APPLICABLE) INFORMATION:

Please provide us with your insurance information or arrange for your dentist to share it with us so we can submit pre-authorizations and claims directly to your insurance company.

Treatment is to be paid by you at the time of your visit. We will then have you sign a claim form and submit to your insurance company for them to reimburse you.

A service charge may be billed to patients who do not provide notice of at least 2 business days to change or cancel a scheduled appointment.

I understand the policies of this office. **Signature:** ___________________________________

CONSENT FOR SERVICES:

I consent to diagnostic procedures that may include a clinical examination, radiographs and photographs. I acknowledge that these may be shared with other dental offices and / or insurance companies. Anonymous records may also be used for teaching / lectures.

If provided, I consent to receive emails from the office. My contact information will never be given out to anyone other than other dental / medical professionals we are communicating with on your behalf.

I authorize the dental office to release all information necessary to preauthorize and / or secure payment for dental services from my insurance company.

I consent to performing of dental and oral surgery procedures including the use of local anesthetic as indicated.

I consent to the above noted services. **Signature:** ___________________________________