ELEMENT DENTAL STUDIO

Guest Registration Form

Please complete all sides of this registration form so that we may provide you with the best possible dental care.

All information is completely confidential.

Name: _____

Date of birth: _____

Home address/city/prov/postal code: _____

Phone number: _____ ☐ Preferred contact method

Email address: _____ ☐ Preferred contact method

Employer: _____ Occupation: _____

Spouse name (if applicable): Spouse Employer:

_____ _____

Saskatchewan Health card number: _____

Emergency Contact Name: _____

Relationship: _____ Contact Phone Number: _____

Responsible party (if someone other than patient):

Name: _____ Relationship: _____

Address: _____ Contact number: _____

Date of Birth: _____ Employer: _____

Medical History

Family Doctor: _____

Family Doctor Address: _____

Current Medical Specialists (if applicable): _____

Have you had any medical care and/or hospitalizations in the past two years?

_____

Allergies

- Acrylic ☐
- Aspirin ☐
- Demerol ☐
- Fluoride ☐
- Hay fever ☐
- Acetaminophen ☐
- Animals ☐
- Codeine ☐
- Erythromycin ☐
- Food ☐
- Iodine ☐
- Local anesthetic ☐
- Morphine ☐
- Sulfate ☐
- Chlorhexidine ☐
- Latex ☐
- Metals ☐
- Penicillin ☐
- Tetracycline ☐
- Ibuprofen/ Advil/Motrin ☐

Other: _____

Conditions

- Abnormal bleeding ☐
- Anemia ☐
- AIDS/HIV infection Angina ☐
- Artificial joint ☐
- Alzheimer's/dementia ☐
- Anxiety ☐
- Artificial heart valve ☐
- Arthritis ☐
- Asthma ☐
- Autoimmune disease ☐
- Blood disease ☐
- Blood thinners ☐
- Bronchitis/respiratory disease ☐
- Cancer/chemo/radiation ☐
- Cold sores ☐
- Cardiovascular disease ☐
- Chronic pain ☐
- Congenital heart disease ☐
- Congestive heart failure ☐
- Diabetes ☐
- Drug/alcohol dependency ☐
- Eating disorder ☐
- Epilepsy ☐
- Fibromyalgia ☐
- Frequent headaches ☐
- GE reflux/heartburn ☐
- Hearing difficulties ☐
- Hepatitis ☐
- Head/neck injury ☐
- Hemophilia ☐
- Heart attack ☐
- High/low blood pressure ☐
- Kidney problems ☐
- Osteoporosis ☐
- Lupus ☐
- Multiple Sclerosis ☐
- Neurological disorder ☐
- Pacemaker ☐
- Psychiatric care ☐
- Premedication ☐
- Parkinson's disease ☐
- Rheumatoid arthritis ☐
- Severe headaches ☐
- Severe weight loss ☐
- Sexually transmitted infection ☐
- Sinus trouble ☐
- Steroid therapy ☐
- Stroke ☐
- Thrush ☐
- Thyroid problems ☐
- TMJ disorder ☐
- Tuberculosis ☐
- Wheelchair access ☐

Other: _____

List all medications and supplements: _____

Are you pregnant or think you could be pregnant: Yes ☐ No ☐

Taking any oral contraceptives? Yes ☐ No ☐ Other ☐

Dental History

What is the reason for your visit today? _____

Previous dental provider: _____

Date of last dental checkup and/or cleaning: _____

How often do you brush? _____ How often do you floss: _____

Do you use any other dental aids to clean your teeth? _____

Are any of your teeth sensitive to: Cold? ☐ Hot? ☐ Sweets? ☐ Biting/chewing? ☐

Any bad mouth odors/tastes? _____

Do your gums bleed or hurt? _____

Have you noticed any changes to your bite? _____

Do you tend to get food caught between your teeth frequently? _____

Do you?

Clench or grind your teeth while awake or asleep? Yes ☐ No ☐

Bite your lips or cheeks regularly? Yes ☐ No ☐

Have unhealthy habits with your teeth (biting nails/pens,etc)? Yes ☐ No ☐

Have any noticeable wear on your teeth? Yes ☐ No ☐

Mouth breathe? Yes ☐ No ☐

Frequently get cold sores, blisters, or ulcers in or around your mouth? Yes ☐ No ☐

Have tired/sore jaws, especially in the morning? Yes ☐ No ☐

Smoke or chew tobacco, vape, or use nicotine pouches? Yes ☐ No ☐

Have you ever had?

Orthodontic treatment? Yes ☐ No ☐

Oral surgery? Yes ☐ No ☐

Gum surgery? Yes ☐ No ☐

A night guard/mouth guard? Yes ☐ No ☐

A serious injury to the head/neck/mouth? Yes ☐ No ☐

Have you experienced?

Clicking or popping of the jaw? Yes ☐ No ☐

Pain in the jaw joint, ear, side of the face? Yes ☐ No ☐

Difficulty in opening or closing your mouth? Yes ☐ No ☐

Difficulty chewing on either or both sides of your mouth? Yes ☐ No ☐

Head/neck/back aches? Yes ☐ No ☐

What would you change about your smile if you could?

_____

Anything else related to having dental treatment you would like us to know?

_____

Consents

- We require a minimum of 24 hours notice to cancel or change any appointment. A fee at our discretion will be charged if an appointment is missed or cancelled without sufficient notice.
- We offer confirmations/reminders both one week and two days before your appointment. Please respond to confirm as you are responsible if the appointment is missed.
- If patient is under 18 years of age, a parent/legal guardian must be present at each appointment initially to consent to the treatment.
- As a service to you, our office will accept direct payment from your insurance company. You are responsible for providing the necessary information in order for us to direct bill your insurance company as well as informing us of any changes in this information.
- Our office provides electronic/manual billing to your insurance company on your behalf. Please note however, that due to the privacy act, you are responsible to be aware of and monitor your plans coverage details and any maximums associated. We can not access this information.
- If your dental plan does not cover the full cost of your treatment you are responsible for any outstanding balance remaining, on the date of your appointment, unless otherwise arranged
- In many cases, we would love to use photos of your smile as part of our case gallery. We will kindly ask you prior to any use of photos and, in any case, they will not be associated with your name or personal information.

I certify that I have provided accurate and complete registration information and have not knowingly omitted anything.

I authorize the dentist and/or his team members to take x-rays, scans, photographs, or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs. I authorize the dentist to perform and apply any and all forms of treatment, medication, and therapy that may be indicated, and consent to the use of local anesthetic agents. I understand the above statements regarding the payment of fees and accept the responsibility for payment for dental services provided for myself or my dependents, due and payable when services are rendered unless other financial arrangements have been made.
I consent to the collection, use, retention and disclosure of personal information as is required for my own and my dependant's dental care.

Signature of patient/guardian: _____ Date: _____

Signature of provider: _____ Date: _____