North Dumfries Dentistry New Patient Registration

Welcome to North Dumfries Dentistry. Here at ND Dentistry, our number one priority is our patients! Please read and fill out our new patient form. If you have any questions, please do not hesitate to ask. We look forward to helping you maintain your dental health!

Section One: Personal Information

First name: ______________________________ Last name: ______________________________

Date of Birth: ____________________________ Gender: *M* *F* *Other*

Preferred Pronouns: ___________________________ Marital status: *Married* *Single* *Separated* *Common law*

Address: ____________________________________ City: ___________________ Post Code:_____________

Preferred method of contact: *Cell* *Home* *Work* *Email*

Cell: _________________________ Home: _________________________ Email: ______________________________

Emergency Contact Name: ____________________________ Phone: _________________ Relation: ___________

Section Two: Dental Insurance Information

Do you have dental insurance coverage? Yes No

If you have more then one dental insurance plan, please fill out BOTH sections with the plan information

Cardholder Name: ___________________________________ Date of Birth:_________________________________

Insurance Company: _________________________________ Plan Number: _________________________________

Subscriber ID:____

Cardholder Name: ___________________________________ Date of Birth:_________________________________

Insurance Company: _________________________________ Plan Number: _________________________________

Subscriber ID:____

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Section One: Dental Information

Former Dentist: ______________________________ City: __________________________

How often do you? Floss: ___________ Brush: ___________ Receive Dental Cleanings: ___________

Do you currently or have you previously had any of the following?

☐ Orthodontic Treatment	☐ Periodontal Treatment	☐ Crowns/Bridges	☐ Implants	☐ Root Canal Therapy
☐ Dentures	☐ Extractions	☐ Fillings	☐ Bleeding Gums	☐ Dry Mouth
☐ Reaction to Anaesthetic	☐ Food Traps in Mouth	☐ Breathing through Mouth	☐ Gag Reflex	☐ Bad Breath
☐ Clicking of Jaw	☐ Mouth/Jaw Pain	☐ Swollen Gums	☐ Grinding Teeth	☐ Lip/Check Biting
☐ Sensitivity to? (Cold Hot Sweets Biting)	☐ Chewing on one side	☐ Loose/Broken teeth	☐ Sores/Growths in Mouth	

Any other oral health concerns

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Section Two: Medical Information

Medications & Dosage

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Have you previously or currently had any of the following?

☐ Cannabis Use	☐ Cigarette Smoking	☐ AIDS/HIV	☐ Hepatitis (Type:)	☐ Cancer (Previously? Y N)
☐ Chemotherapy/Radiation Treatment (Previously? Y N)	☐ Kidney Disease	☐ Liver Disease	☐ Heart Condition/Disease	☐ Blood Disease
☐ Thyroid Problems	☐ Stomach Problems	☐ Sinus Problems	☐ Respiratory Problems	☐ Diabetes (Type:)
☐ High Blood Pressure	☐ Excessive Bleeding	☐ Arthritis	☐ Artificial Joints	☐ Stroke
☐ Anemia	☐ Pregnancy (Previously? Y N)			

Additional Medical Information (Examples: Allergies, Any other medical information you would like to tell us about, etc)

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Section Three: Authorization

I confirm that I have filled out this form with truthful information. I understand that I am held liable to pay for charges from the dental treatment I receive, also applying to outstanding balance remaining after insurance payments.

______________________________ ______________________

Signature Date