MARKET SQUARE DENTAL

DR. MICHELLE SZASZ DDS

PATIENT REGISTRATION

Name of Client____ Male ( ) Female ( )

(Parent if CLIENT is under 16)______________________________ Healthcard #______________________________

Mailing Address:____ City:____________________________________

Province:___________________ Postal Code: ________________________ Birthdate:_________________________

Home Phone#____________________ Business Phone# ___________________ Cell Phone#____________________

E-Mail Address: ____

How would you like to receive appointment reminders? Email or Text (please circle preference/consent)

Who may we thank for referring you to our office? ____

PERSON TO CONTACT IN CASE OF EMERGENCY: Phone:____

Name:________________________________ Relationship to Client:_________________________________

DENTAL INSURANCE Policy Holder ( ) Self ( ) Spouse ( ) Other

Place of Employment: ____

Ins. Company:________________________ Policy# ___________________ I.D. #_____________________________

We are committed to keeping your personal information private.
By signing the consent form on the back of this page, you have agreed to give consent for the collection, use and/or disclosure of your personal information for the purposes that are listed on our Private Policy. If a new purpose arises for the use and/or disclosure of personal information, we will seek your approval in advance. A copy of our Private Policy is available in the reception area.

PAYMENT OPTIONS:

To keep costs down and to continue to provide quality dentistry, we can only accept payment in full, same day of service. I understand that the responsibility for payment for Dental Services provided in this office for myself or dependants is mine, due and payable at the time services are rendered. I further understand that a 1.5% monthly interest charge (18% annually) will be added to any balance over 60 days. In the event of a default, I(we) promise to pay any interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required, to effect collection of this note.

We accept: CASH/INTERACT VISA MASTERCARD as methods of payment.

PRINT NAME: _______________________________________ DATE: ________________________

SIGNATURE: ____

PLEASE COMPLETE ALL OF BELOW:

DENTAL HISTORY:

1. Do you smoke? YES NO How much? ___________________________
2. Are you having any discomfort at this time? YES NO
3. Do you feel nervous about having dental treatment? YES NO
4. Have you ever had a bad experience in the dental office? ____ YES NO
5. When was your last dental appointment? ____

HEALTH HISTORY:

1. Physician's name____PhoneNumber:________________
2. Date of last physical? ____
3. Please list any medications you are presently taking.____
4. Do you have any allergies? ____
5. Have you ever been told you should take an antibiotic before dental treatment? YES NO
6. Have you ever taken Alendronate (Fosomax),Editronate(Didrocal), Risedronate(Actonel) or Pamidronate(Aredia)? YES NO
7. Have you ever had a peculiar or adverse reaction of any of the following? (Please Circle)

LATEX NITROUS OXIDE LOCAL ANAESTHETIC (DENTAL FREEZING) PENICILLIN ASPIRIN

Other (Please specify) ____

8. Have you ever had a joint replacement? YES N0

9. Have you ever had a problem with alcohol or drug dependency? ____ YES NO

10. For women only: Do you take birth control pills? YES NO Are you pregnant? _______________________ YES NO

DO YOU NOW, OR HAVE YOU EVER HAD THE FOLLOWING (Please Circle)

Heart disease or attack	Emphysema	HIV	Hepatitis A B C
High Blood Pressure	Angina	A.I.D.S	Diabetes
Congenital Heart Lesions	Asthma	Yellow Jaundice	Haemophilia
Scarlet Fever	Allergies or Hives	Tuberculosis	Venereal Disease
Artificial Heart Valve	Arthritis	Epilepsy/Seizures	Chemotherapy/Cancer
Heart Pacemaker	Rheumatic Fever	Nervousness	Sickle Cell Disease
Heart Surgery	Osteoporosis	Bruise Easily	Anemia
Kidney Trouble	Pain in Jaw	Liver Disease	Heart Murmur

11. Do you use two or more pillows to sleep? ____YES NO

12. Do you ever wake up from sleep short of breath? ____YES NO

13. Have you lost or gained more than 10 pounds in the past year?____ YES NO

14. Has your medical doctor ever said that you have cancer or a tumour ?____YES NO

15. Are you on a special diet?____ YES NO

16. Do you have any disease, condition or problem not listed? ____ YES NO

CONSENT

The undersigned herby authorize the Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my(or patients') dental needs. I authorized the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I further authorize and consent that the Doctor choose and employ such assistance, as he/she deems fit. I also understand that the use of anaesthetic agents embodies a certain risk. Where possible, I will be asked for verbal consent before any and all treatment is done, and x-rays are taken.

Patient Signature____

Date____

Or

PARENT OR RESPONSIBLE PARTY____

RELATIONSHIP TO PATIENT____