New Patient Registration Date: _____

Patient Information			
First Name	Last Name	Middle Initial	Date of Birth
Address / City		Province	Postal Code
Phone Number	E-Mail Address	Family Doctor	
Do you have dental insurance? ☐ Yes ☐ No			

Emergency Contact Information		
First Name	Last Name	Phone Number

Medical History	
Within the last 3 years, have you been hospitalized or had surgery?	☐ Yes ☐ No
If yes, please give details and dates: _____	
Are you currently, or have you ever undergone radiation or chemotherapy treatments?	☐ Yes ☐ No
Are you taking or have you ever been treated with a bisphosphonate (Fosamax) for osteoporosis?	☐ Yes ☐ No
Are you allergic to or had reaction to any of the following medications?	☐Penicillin ☐Codeine ☐NSAID (Ibuprofen, Celebrex, Vioxx, Anaprox) ☐Erythromycin ☐Keflex (Cephalexin) ☐Clindamycin ☐Sulpha ☐Latex
Are you currently taking a blood thinner? (ie, Warfarin, Eliquis, Pradaxa, Heparin)	☐ Yes ☐ No
Have you had an unusual reaction to any other medication not listed above? _____	
Please list any drug/medicine/herb you are currently taking: _____	

Do you currently have, or have you ever had, any of the following?			
Heart Disease Details: _____	☐ Yes ☐ No	Hepatitis, Jaundice, or Other Liver Disease	☐ Yes ☐ No
Heart Surgery	☐ Yes ☐ No	Organ Transplant	☐ Yes ☐ No
High or Low Blood Pressure (circle)	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Pacemaker / Artificial Heart Valve	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Heart Attack Date:_____	☐ Yes ☐ No	Thyroid Problem or Disease	☐ Yes ☐ No
Infective Endocarditis	☐ Yes ☐ No	Glaucoma or Eye Disease	☐ Yes ☐ No
Stroke Date:_____	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Ulcers / Acid Reflux / Stomach Problems	☐ Yes ☐ No
Diabetes or Blood Sugar Problems	☐ Yes ☐ No	Compromised Immune System	☐ Yes ☐ No
Artificial Joint Replacement	☐ Yes ☐ No	Mental Health Issues	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	Are you Pregnant, or Think You May Be?	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Are you Breastfeeding?	☐ Yes ☐ No
Any Form of Cancer Type / Year : _____	☐ Yes ☐ No	Do You Use Tobacco Products?	☐ Yes ☐ No
Sleep Apnea / CPAP	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No

Are there any other medical conditions that we should be made aware of? _____ _____	
Have you had any serious trouble associated with a previous dental treatment? _____ _____	
Chief dental complaint (why did you come to the office today?) _____ _____	
How did you hear about us?	☐Radio ☐Newspaper ☐Social media ☐Billboard ☐Friend ☐Doctor (Name: _____)☐Other _____

Consent – To the best of my knowledge, all the above information is correct, and I will inform Island Roots Dental of any future changes in health or medication. I also consent Island Roots Dental to contact other healthcare or insurance providers on my behalf, and to have my health and contact information released for referrals or to aid in my care and treatment. I also consent to diagnosis and treatment performed as recommended by Island Roots Dental.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that the dentist will submit my insurance claims as a service to me but is not a party to the insurance contract or responsible for their decisions regarding benefits. I agree to be responsible for payment of all services rendered on my behalf or my dependents including all costs that the dental plan does not cover.

Signature: _____ Date: _____

Reviewed By: _____

Thank you!