Dr. Bobby Brown and Associates
145-33 City Centre Drive.
Mississauga, ON L5B2N5

PATIENT REGISTRATION

ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Name _____ Nickname_____
(FIRST) (LAST)

☐ Male ☐ Female Date of Birth M/D/Y _____/_____/_____ Birth Place _____

Home Address_____

City_____ Postal Code_____

Home Number_____ Cell Number_____

Business Number_____Ext._____ E-mail Address _____

How would you like to have your appointment confirmed? ☐ Home ☐ Cell ☐ Business ☐ E-mail
Other_____

Marital Status_____Children Yes/No

Occupation_____Employer_____
Person responsible for Payment Myself/Father/Mother/Spouse/Other_____
Do you have Dental Insurance ☐ YES ☐ NO

PRIMARY INSURANCE Myself Insured Name_____

Employer_____ Date of Birth M/D/Y _____/_____/_____ Relationship_____

Address (same as above)_____ City_____ Postal Code_____

Insurance Company Name_____Policy/Plan/Contract#_____

ID or Certificate Number _____

SECONDARY INSURANCE Myself Insured Name_____

Employer_____ Date of Birth M/D/Y _____/_____/_____ Relationship_____

Address (same as above)_____ City_____ Postal Code_____

Insurance Company Name_____Policy/Plan/Contract#_____

IN CASE OF EMERGENCY PLEASE CONTACT
_____ AT #_____ RELATIONSHIP_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Patient or Guardian Signature:_____ Date: M/D/Y/ _____

MEDICAL HISTORY

Date of last complete PHYSICAL _____ Name of PHYSICIAN _____

Phone Number _____ Address _____

Are you in good heath? Yes No Do you have or have you had any serious illnesses or operations? _____

_____

Have you ever been told that you require **Pre-medication** for your dental appointments? Yes ☐ No ☐

If so why? _____

Are you under the care of a physician at the present time? Yes ☐ No ☐ Are you taking any medications now? Yes ☐ No ☐

*If so please use **Medication List** form provided.

Have you ever been warned against taking any medicines / drugs? If yes please list _____

_____

Are you on a special diet? Yes ☐ No ☐ what kind? _____ Salt restricted? Yes ☐ No ☐

Are you allergic to latex? Yes ☐ No ☐

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Aspirin ☐ Other Drugs ☐ Food Colorings/Dyes ☐ Metals? ☐ Food? Other? _____

Have you had or have you been treated for any of the following? (Please circle any that apply)

Rheumatic Fever Heart Disease Heart Murmur Heart Surgery Heart Attack Angina Pacemaker Anemia Blood Disorders

High Blood Pressure Blood Transfusion Hemophilia Bleed/Bruise Easily Stroke Hip or Joint Replacement Diabetes M.S.

Kidney/Liver Disease Mental/Nervous Disease Thyroid Disease Glaucoma Muscular Dystrophy Jaundice Hay Fever

Fainting Spells Cold Sores Ulcers Gall Bladder Tuberculosis Cancer Chemotherapy Radiation Therapy Dialysis Asthma

Epilepsy Arthritis Hepatitis HIV Aids Venereal Disease Alcoholism/Drug Addiction Other? _____

_____

Is there a History of Family Disease? Yes ☐ No ☐ If yes please list: _____

_____

Do you get chest pains on exertion? Yes ☐ No ☐ Do your ankles swell? Yes ☐ No ☐

Have you noticed: Increased thirst Increased frequency of urination Unexplained weight loss Other? _____

_____

Women Only:

Are you Pregnant? Yes ☐ No ☐ Maybe ☐ If yes how many months? _____

Are you on Birth Control? Yes ☐ No ☐ **Did you know that antibiotics reduce the effect of Birth Control Pills?**

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment.

I acknowledge that I am responsible for informing the doctor of any changes in my health history prior to treatment.

Patient or Guardian Signature: _____ Date M/D/Y _____/_____/_____