CAPTIVATE DENTAL
cosmetic and general dental solutions

PATIENT REGISTRATION

Date: ___ / ___ /___

Surname: _____ **First Name:** _____ **Title:** _____

Date of Birth: _____ **Gender:** ☐ **M** ☐ **F**

Home Address: _____

Business Address: _____

email Address: _____ **Home Phone No:** _____

Work Phone No: _____ **Mobile Phone No:** _____

Fax Number: _____ **Occupation:** _____

Health Fund: _____

Is another Member of your Family a Patient at our Office? **YES / NO**

Name: _____ **Relationship:** _____

Who were you referred by?: _____

Name of Parent/Guardian: _____

Person to Contact in Case of Emergency: _____ **Phone:** _____

Address: _____

Closest Relative not Living with You: _____ **Phone:** _____

Address: _____

Person Responsible for Account: _____ **Phone:** _____

Address: _____

Relationship to Patient: _____

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CONSENT FOR TREATMENT

1. I hereby authorise doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2. Upon such diagnosis, I authorise doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If required, I also understand a check of my credit history may be made.

Patient's Signature: _____ Date: _____

Parent/Responsible Party's Signature: _____ Relationship to Patient: _____

MV1010

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DENTAL HISTORY

Patient Name	
Patient Account Number	Medical Alert

Welcome! So that we may provide you with the best possible care, please complete BOTH SIDES of this Medical/Dental History Form. All information is completely confidential.

What is the reason for your visit today?_____
Date of last dental visit_____ Last dental cleaning_____Last full mouth X-rays_____
What was done at your last dental visit? _____
Previous Dentist's Name _____
Address _____State_____P/Code_____
Telephone_____

How often do you have dental examinations? _____
How often do you brush your teeth?_____How often do you floss?_____
What other aids do you use? (Interplak, toothpick, etc)_____

Do you have any dental problems now? Yes/No
If yes, please describe:_____

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odours or bad tastes?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
Do you frequently get sores, blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught between your teeth?	Yes	No

If yes, where?_____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects in your teeth (pencils, pipe, pins, nails, fingernails)?	Yes	No
Breathe through your mouth while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/Chew tobacco?	Yes	No

Have you ever had:

Orthodontic Treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or a mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
Any previous problems with dental infections?	Yes	No

If so, please describe, inluding cause?
_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain (joint, ear, side of face)?	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches, or shoulder aches?	Yes	No
Sore Muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?
_____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe_____
_____

Is there anything else about having dental treatment that you would like us to know? _____
_____
If yes, please describe:_____

MV1030

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MEDICAL HISTORY

Patient Name:	
Patient Account No.	Medical Alert:

1. Have you been under the care of a medical doctor during the past two years?..... Yes No
   If yes, for what?_____
   Physician's Name _____ Phone_____
   Address _____ State _____ Postcode_____
2. Have you taken any medication or drugs during the past two years?..... Yes No
3. Are you taking any medication, drugs or pills now? ..... Yes No
   If yes, please list name and dosage: _____
4. Are you aware of having an allergic (or adverse) reaction to any medication or substance? ..... Yes No
   If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ..... Yes No

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Haemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Troubles	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Have you lost or gained more than 10 pounds in the past year?..... Yes No
8. Do you have or have you had any disease, condition, or problem not listed ..... Yes No
   If yes, please list:_____
9. **Women:** Are you: **Pregnant?** Yes___Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any change in my health or medication.

Patient/Guardian Signature_____Date_____

History Review

Dentist Signature_____Date_____

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