Cumberland Dental Centre

Dr. Chris Becir, Dr. Jana Lamb

Confidential Patient Record and Medical History

PATIENT REGISTRATION:

Are you the: ☐Patient ☐Parent ☐Guardian

Name: _____
First Last Initial

Address: _____
Box Number Street City Province

Postal Code: _____ Date of Birth: _____ Sex: M / F

Phone Number: _____
Home Cell Phone Work Ext

In Case of Emergency: _____ Contact Number: _____ Relationship: _____

Family Physician: _____ Phone Number: _____

Email: _____ Do you prefer to be notified by: **Email / Phone / Work/ Text**

Person Responsible for Account: Self Parent, Guardian or Spouse: _____

Whom may we thank for referring you to our office: _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance	**Secondary Dental Insurance**
Name of Insured: _____	**Name of Insured:** _____
Policy Holder Date of Birth: _____	**Policy Holder Date of Birth:** _____
Employer: _____	**Employer:** _____
Id# _____ **Policy Number:** _____	**Id#** _____ **Policy Number:** _____
Basic: _____ **% Major:** _____ **%**	**Basic:** _____ **% Major:** _____ **%**
Deductible: _____ **Financial Limit:** _____	**Deductible:** _____ **Financial Limit:** _____
Additional Information: _____	**Additional Information:** _____

Every dental plan is different, treatment recommendations are based on your dental health needs not dictated by your dental coverage. Coverage varies based on what services are covered under your contract. It is your responsibility to know your plan coverage and notify us of any changes. Our office will do our best to help you understand your coverage. **Initial:** _____

Patient Dental History:

Reason for the Visit today at our office: _____

When was your last dental Visit: _____

When was your last dental cleaning appointment and x-rays: _____

PAGE 1 NEXT FOR PAGE 2

NAME:_____

MEDICAL HISTORY PAGE 2

Do you have, or have you had, any of the following *(if yes, please check)*:

◇ Heart Failure	◇ Rheumatic Fever	◇Asthma	◇Epilepsy/Seizure	Alcohol/Chemical Dependency: _____
◇ Heart Disease/Attack	◇Scarlet Fever	◇ Sinus Trouble	◇ S.T.D's	◇ HIV / AIDS Positive
◇ Heart Pacemaker	◇Blood Disorders	◇Allergies or Hives	◇Fainting	◇Hepatitis A / B / C
◇Artificial Heart Valve	◇Mental Illness	◇Thyroid Disease	◇Blood Transfusion	◇Artificial Joint:_____
◇Angina	◇Kidney Trouble	◇Venereal Disease	◇Pain of the Jaw Joints	◇Cancer:_____
◇ High Blood Pressure	◇Tuberculosis (TB)	◇Cortisone Medication	◇ Latex Allergy	◇ Genital Herpes

1) Do you have any disease, disorder or problem not listed above? Yes / No
   If yes, please state: _____

2) Do you require Pre-Medication for dental treatment? Yes / No

3) Do you have any conditions currently being treated by a physician or specialist? Yes / No

4) Are you presently taking any drugs, medication, vitamins or supplements? Yes / No
   If yes, please state:
   _____
   _____

5) Do you have any allergies or sensitivities? Yes / No
   If yes, please state: _____

6) Do you smoke? Yes / No
   If yes, how much and how often? _____

7) Are you taking bisphosphonates now or have you ever taken them in the past (e.g. Fosamax, Zometa) Yes / No
   If yes, please specify: _____

8) **Women Only:** Are you Pregnant? Yes / No How far along are you? _____ Are you nursing? Yes / No

General Release

I, undersigned, certify that I have provided an accurate and complete personal and medical/ dental history and have not knowingly omitted any information, I have had the opportunity to ask questions and received answers to any questions regarding my medical. Dental history. Should there be any change in my health states in the future, I will advise this dental office. I authorized the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for me and my dependents is mine, and I assume responsibility for fees associated with these services

_____ _____

Signature of Patient / Parent / Guardian ***Please Print Name***

We require a minimum of 24hr notice for cancelling an appointment. A No Show fee could be applied to your account if there is insufficient notice given for the cancellation. Initial: _____

Reviewed By Treating Dentist: _____ **Date:** _____