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: _____

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
Congential 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	Osteoperosis	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's) 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_____