WELCOME TO DR FREMETH & DR. PROSZANSKI'S DENTAL OFFICE

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. If you have any questions or doubts, please ask the treating dentist or our receptionist. All information is strictly confidential and will remain with this office. **PLEASE PRINT.**

PATIENT REGISTRATION INFORMATION

DATE: ______________________________

Name: ____ Date of Birth: ____________________
Last First

Address: ____
Street City Prov. Postal Code

Home Phone: ____________________ Work Phone: ______________________ Cell: _________________

Spouse Work: ____________________ Spouse Cell: ______________________

Email Address: ____

In case of Emergency: ____
Name Relationship Phone

Person Responsible for account: ___________________________________ Phone: ____________________
Workplace (Company): ____ Phone: ____________________
Work Address: ____

Do you have Dental Insurance? YES NO Name of insurance company: ____________________________
Group/Policy #: _______________________ Policy holder: __________________________________
Certificate/ID #: _______________________ Date of Birth: __________________________________

Are you covered by any Social Assistance Program? YES NO If yes, which program? __________________

Whom may we thank for referring you? ______________________________ Phone: ____________________

DENTAL HISTORY

1. When was your last dental visit? ____
2. Name of previous dentist: ____
3. When did you last have dental x-rays? ____
4. How often do you brush your teeth? ____
5. How often do you floss your teeth? ____

	Yes	Maybe/ Not Sure	No
6. Have you been seeing a dentist regularly?	[ ]	[ ]	[ ]
7. Do any of your teeth ache?	[ ]	[ ]	[ ]
8. Have you ever been advised to take antibiotics before dental appointments?	[ ]	[ ]	[ ]
9. Do your gums bleed when you brush?	[ ]	[ ]	[ ]
10. Do you have any pain when you chew?	[ ]	[ ]	[ ]
11. Do you feel that you have bad breath?	[ ]	[ ]	[ ]
12. Have you ever been in a vehicle accident or experienced any pain in your jaw joints?	[ ]	[ ]	[ ]
13. Have you ever had any implant surgery in one or both of your jaws or jaw joints?	[ ]	[ ]	[ ]

14. If you answered yes to the last question, who performed the surgery and when was it done? ____
15. Are you being followed by a dental specialist? _______________________________________
16. Please list anything else not mentioned above regarding your past dental history. ____________________
____

PLEASE SEE REVERSE.

MEDICAL HISTORY

1. Date of last **medical** examination: ____

2. Name of family physician: ____

3. Is your physician treating you now? [ ] Yes [ ] No Specify: ______________________
____
____

4. Are you being treated by a medical specialist? [ ] Yes [ ] No Specify:
____
____

5. Are you on medication or herbal remedies or supplements? [ ] Yes [ ] No Please List:
____
____
____

6. Do you have any allergies? [ ] Yes [ ] No Please specify: ________________________

7. Have you **ever had** or been treated for? (**Please circle**)

Respiratory Disease	High Blood Pressure	Hepatitis A	Herpes	Tuberculosis
Rheumatic Fever	Low Blood Pressure	Hepatitis B	Stroke	Liver Disease
Scarlet Fever	Bleeding Disorder	Hepatitis C	Gastric Ulcer	Heart Disease
Shortness of Breath	Arthritis	Epilepsy	Dizzy Spells	Aids or HIV Positive
Thyroid Disease	Blood Disorders	Diabetes	Asthma	Chest Pain
Kidney Disease	Venereal Disease	Sinus	Heart Murmur	Environmental Allergies
Psychiatric Disease	Artificial Joints	Pacemaker	Disease of Eyes, Ears, Nose or Throat	
Mitral Valve Prolapse	Anemia	Cancer ______________		

8. Are you pregnant? [ ] Yes [ ] No Month: ______________

9. Do you smoke? [ ] Yes [ ] No ______________________

10. Is there any other medical condition we should be made aware of? ______________________
____
____
____
____
____

I, the undersigned, certify that I have provided and accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. **Should there be any change in my health status in the future, I will advise this dental office.** I authorize 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 service for myself and my dependants is mine and I assume responsibility for fees associated with these services.

X ____________________________________ Print Name: ____________________

Signature Patient [ ] Parent [ ] Guardian [ ]

Reviewed by Treating Dentist: ______________________ Date: ______________________

OFFICE POLICY

1. **To avoid charges, please notify our office with 48 hours notice if you are unable to attend your scheduled appointment. A $75 charge applies for no shows or cancellations with out notice.**
2. **Dental Insurance is an agreement between you and your insurance company. We do not accept payment directly from the insurance company. You are expected to settle the account following treatment.**