CHOLAKIS DENTAL GROUP

120-2025 Corydon Avenue • Winnipeg, MB R3P 0N5 • 204-488-4564 • www.cholakisdental.com

PATIENT'S NAME____ D.O.B.: ______________________
Last First Initial MM / DD / YY

Gender (M/F): ________ Marital Status: ______________________ S.I.N.: ______________________

Driver's License #: ______________________ Manitoba Health #: ______________________

Address: ____
Street City Province Postal Code

Phone #"s: Home____________ Work ____________ Ext. ______ Fax ____________

Pager____________ Cellular ____________ E-mail ______________________

Who may we thank for this referral?____

Patient lives with: Mother / Father / Both / Self / Husband / Wife / Other ______________________

Patient / Parent Employed by: ______________________ Position ______________________

Driver's License #: ______________________ S.I.N.: ______________________

Parent / Spouse Employed by: ______________________ Position ______________________

Driver's License #: ______________________ S.I.N.: ______________________

Method Payment: Insurance ☐ Credit Card ☐ Cash ☐

Other Family Members in this Practice____

DENTAL INSURANCE 1st COVERAGE	**DENTAL INSURANCE 2nd COVERAGE**
Employee Name: ______________________	Employee Name: ______________________
D.O.B.: ______________________ MM / DD / YY	D.O.B.: ______________________ MM / DD / YY
Employer: ______________________	Employer: ______________________
Insurance Co.: ______________________	Insurance Co.: ______________________
Group or Policy #: ______________________	Group or Policy #: ______________________
Certificate #: ______________________	Certificate #: ______________________
Employee #: ______________________	Employee #: ______________________
Division #: ______________________	Division #: ______________________
I.D. #: ______________________	I.D. #: ______________________

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist or medical professional.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.

I understand that by providing my email address I may be emailed periodically by Cholakis Dental (or our related sister clinics) regarding promotions, newsletters and various marketing initiatives, and may unsubscribe at any time.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature: ______________________ Date: ______________________

REGISTRATION

PATIENT'S NAME____ D.O.B.: ______________________

Last First Initial MM / DD / YY

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUEISTON.

1. Name of Physician ______________________________________

   Address______________________________________

   Phone # ______________________________________

2. Have you ever had a serious illness or are you under the care of a physician? .... YES NO

3. Have you had a medical exam in the last year?. .... YES NO

4. Do you use or have you used any tobacco products? .... YES NO

   If so, how much and how long? ______________________________________

5. Are you currently taking any medications or health related products? ______________________ YES NO

   If yes, list <u>all</u> mediations ______________________________________

   ____

   ____

6. Do you have any of the following diseases or problems (please circle)*(please circle)*

High Blood Pressure	Stroke	Hepatitis	Cancer
Heart Attack	Asthma/Hay Fev er	Tuberculosis	Heart Disease
Seizures/Fainting Spells	HIV / AIDS	Heart Murmur	Diabetes
Arthritis	Stomach Problems	Kidney Problems	Liver Problems
Blood Disorder	Psychiatric Disorder	Rheumatic Fever	

   Other: ______________________________________

7. Do you have a prosthetic heart valve or prosthetic joint? .... YES NO

8. Has your physician requested that you take antibiotics prior to dental treatment?.. YES NO

9. Do you have a pacemaker?.. YES NO

10. Do you have an allergy or have you had an unusual reaction to: Latex ☐ Metals ☐

11. Do you have an allergy or have you had an unusual reaction to any of the following medications? (Please Circle)

Aspirin	Codeine	Erythromycin	Valium
Tylenol	Morphine	Sulfas	Sleeping Pills
Ibuprofen	Penicillin	Clindomycin	Local Anaesthetics
NS Aids	Cephalosporins	Tetracycline	

   Other: ______________________________________

12. Are you pregnant? (which month ____). .... YES NO

13. Are you currently breastfeeding?.. YES NO

14. Do you have any disease, condition, problem not listed above, that the doctor should know about? .... YES NO

   Explain:______________________________________

15. Have you had any serious trouble associated with previous dental treatments? .... YES NO

   Explain:______________________________________

COMMENTS

ANEST.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE______________________________ DATE ____________

MED. ALERT

MEDICAL HISTORY

PATIENT'S NAME ____
Last First Initial Date of Birth

COMMENTS

1. Purpose of initial visit? ______________________________
2. Are you aware of a problem? ______________________________
3. How long since your last visit? ______________________________
4. What was done at that time? ______________________________
5. Previous dentist's name ______________________________
   Address ______________________________ Tel.: ______________
6. When was the last time your teeth were cleaned? ______________

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESITON.

7. Have you made regular visits? .... YES NO
   How often: ______________________________
8. Were dental x-rays taken? .... YES NO
9. How often do you brush your teeth ______________ When? ______________
10. Do you use dental floss or other aids .... YES NO
    What and how often? ______________________________
11. Have you lost any teeth or have any teeth been removed .... YES NO
    If so, why? ______________________________
12. Have they been replaced? .... YES NO
13. a) Fixed bridge ______________ How long ago ______________
    b) Removable denture ______________ How long ago ______________
    c) Implants ______________ How long ago ______________
14. Are you dissatisfied with the replacements? .... YES NO
    If yes, explain ______________________________
15. Do your gums bleed or hurt when you brush? .... YES NO
    When? ______________________________
16. Are you aware of loose teeth? .... YES NO
17. Does food get caught in your teeth? .... YES NO
18. Have you ever been diagnosed with periodontal disease or have had gum surgery .... YES NO
19. Are your teeth sensitive to ☐ Hot ☐ Cold ☐ Sweet ☐ Pressure?
20. Do you clench or grind your teeth? .... YES NO
21. Does your jaw click or pop? .... YES NO
22. Have you experienced any pain or soreness in the chewing muscles of your face or around your ear? .... YES NO
23. Do you have frequent headaches, neckaches or shoulder aches? .... YES NO
24. Do you currently wear a nightguard? .... YES NO
25. Are you concerned with the colour of your teeth? .... YES NO
26. Are you concerned with the appearance of your teeth? .... YES NO
27. Are you concerned with the arrangement or alignment of your teeth .... YES NO
28. Are any of your teeth loose, tipped, shifted or chipped? .... YES NO
29. How do you feel about your teeth in general? ______________________________
30. Do you feel you frequently have bad breath (halatosis)? .... YES NO
31. How long have you had halatosis? ______________________________
32. What do you currently do to help your halatosis? ______________________________
33. Do you frequently snore at night? .... YES NO
34. Do you experience sleep apnea? .... YES NO
35. Have you had any orthodontic work? .... YES NO
36. Have you had any unpleasant dental experiences or is there anything about dentistry that you dislike? ______________
37. Do you have any questions or concerns? .... YES NO

ANEST.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE ______________________________ DATE ______________

MED. ALERT

DENTAL HISTORY