Patient Registration

McDONOUGH
DENTAL

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Rev. Date Of Birth : _____ _____ _____
year month day

Name: _____
last name first name initial

Address: _____Unit:_____

City: _____ Province: _____ Postal Code:_____

Email:_____
email is ONLY used to contact your regarding dental appointments and correspondence.

Phone: _____ _____ _____
home cell work/other

PREVIOUS DENTAL CARE

Previous Dentist: _____
name phone number

Date Of Last Visit: _____ Last Recall / Cleaning:_____

PRIMARY DENTAL INSURANCE INFORMATION

Name Of Policy Holder: _____ Date Of Birth : _____ _____ _____
year month day

Insurance Company: _____ Plan#:_____ ID#:_____

SECONDARY DENTAL INSURANCE INFORMATION

Name Of Policy Holder: _____ Date Of Birth : _____ _____ _____
year month day

Insurance Company: _____ Plan#:_____ ID#:_____

Who should we contact in case of emergency: _____ _____
name phone number

Is there someone we can thank for referring you to our office? _____

Please Note: Consultation with your medical doctor, dental specialist or pharmacist may be necessary to ensure your safe treatment. All information is strictly confidential. I permit McDonough Dental and all associates to request information and consult with my physicians, specialists and pharmacist, and to release information to my dental insurance company. I permit McDonough Dental and associates to perform dental and oral surgical procedures agreed to be necessary or advisable and I assume responsibility for the cost of these procedures.

Name:_____ Signature: _____ Date_____

McDONOUGH
DENTAL

Date _____

PERSONAL INFORMATION

Legal Name _____ Preferred Name _____

Preferred Pronoun her/she his/he they Date of Birth _____ Age _____ Gender M F NB

Home Address _____

City _____ Prov _____ Postal Code _____

Email _____

Telephone – Circle preferred Home _____ Mobile _____ Work _____

Referred by _____ Emergency contact Name _____ Telephone _____

MEDICAL HISTORY

CIRCLE

Do you regularly see your physician? YES NO

Medications - Please list or provide list from pharmacy _____ YES NO

_____

Allergies - Please list _____ YES NO

Have you ever had a reaction to medication? YES NO

Please circle all that apply for past or present diseases or conditions:

Heart	Thyroid	Kidney	Liver	Blood Pressure	Bleeding
Osteoporosis	Autoimmune	Stroke/TIA	Cancer	Infective endocarditis	Surgery
HIV/AIDS	Breathing/asthma	Joint replacement		Epilepsy/seizures	
Immunosuppressants/chemo/radiation			Smoking	Pregnant	Diabetes I/II

(For office use only)

_____

_____

_____

_____

Blood pressure at appt _____

DENTAL HISTORY

When was your last dental appointment? _____

Have you ever had a bad experience in regards to dental treatment? YES NO

Are you nervous or anxious having dental work completed? YES NO

PERMIT FOR OPERATIONS

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable including the use of local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (Parent's) Signature _____ Date _____

McDONOUGH
DENTAL

Authorization To Contact

Date: _____

Patient Name (s):

_____

_____

_____

I authorize you to contact me regarding my (and my family members') dental appointments, and I further authorize you to contact dental specialists and my dental insurance on my behalf, using…

☐ E-mail. My preferred address is:

_____

☐ Phone. My preferred phone number is:

_____

I understand that I can withdraw this authorization at any time by reply e-mail, or by calling the office directly.

Signed: _____ Date:_____