Country Hills DENTISTRY
DR. TIM JOHNSTON & ASSOCIATES

Date month/day/year ______/______/_______

In order to provide you with the highest standard of dental care, please provide our dental office with the following Personal Information and Medical and Dental Histories. The protection and privacy of your personal information is important to our office and we are committed to collecting, using, disclosing this information responsibly. ***Please complete this form by neatly printing.***

ADULT PATIENT REGISTRATION INFORMATION

Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms ☐ Other:____________		
Name: (Last, First, Ini)		DOB:
Address:		
Home Phone:	Mobile:	Email

In the future, please circle how we may contact you to confirm your appointments: Email or Telephone (home or mobile)

Employer Name:	*Employer Phone Number:*
Family Physician Name:	*Physician Phone Number:*
Your Spouse's Name:	
Your Spouse's Employer:	*Spouse's Employer Phone Number:*
Emergency Contact Name:	*Phone:*
Is another family member a patient here at our office? Yes ☐ or No ☐	*If yes, Name:*

CHILD PATIENT REGISTRATION INFORMATION

Name: (Last, First, Ini)	DOB:
Address: (if different from above)	
Home Phone: (if different from above)	Mobile: (if different from above)
School:	Grade
Emergency Contact Name:	Phone:
Is another family member a patient here at our office? Yes ☐ or No ☐	If yes, Name:

MEDICATIONS: ***LIST ALL PRESCRIPTION, NON-PRESCRIPTION, HERBAL MEDICATIONS THAT YOU ARE TAKING-- INCLUDE NAME, DOSE AND FREQUENCY. (**IF THE LIST IS LENGTHY PLEASE GIVE LIST TO RECEPTIONIST TO PHOTO COPY**)***		
Pharmacy Name:	Pharmacy Phone Number	

INSURANCE INFORMATION	*Single Coverage*		*Double Coverage*
Name of Insured & Birthday		Name of Insured & Birthday	
Primary Insurance Carrier		Secondary Insurance Carrier	
Group/Policy Number		Secondary Group/Policy Number	
I.D. Number		Secondary I.D. Number	
Division Number		Secondary Division Number	

MEDICAL INFORMATION (circle one)

Have you ever had extensive medical care? Yes ☐ or No ☐	*Describe*
Are you presently under the care of a physician? Yes ☐ or No ☐	*Describe*
Have you been hospitalized in the last 5 years? Yes ☐ or No ☐	*Describe*
Have you had a medical examination in the last year? Yes ☐ or No ☐	Date: Type:
Do you have any allergies to any medication? Yes ☐ or No ☐	If yes, please describe:
Do you have any allergic conditions? (i.e. latex, metal, food allergies) ? Yes ☐ or No ☐	
Have you ever been advised **not to take** a certain drug or medication? Yes ☐ or No ☐	Describe
Has your Doctor ever told you **to take antibiotics** prior to a dental procedure? Yes ☐ or No ☐	If yes, when?

Please circle if you have a history of any of the following:

Heart Murmur or Mitral Valve Prolapse	Malignant Hyperthermia	Hepatitis A/B/C	Liver Disease/Jaundice
Stomach/intestinal problems	Positive Testing for HIV/AIDS	Joint Replacement (hip, knee, etc.)	Venereal Disease
Heart Attack/Stroke	Herpes	Mental or Nervous Disorders	Lung Disease
Cortisone/Steroid Therapy	Cold Sore	Sinus Trouble	High Blood Pressure
Thyroid Disease	Diabetes	Cancer	Low Blood Pressure
Arthritis or Rheumatism	Tuberculosis	Kidney Disease	Epilepsy or Seizures
Hypoglycemia/Hyperglycemia	Scarlet/Rheumatic Fever	Drug/Alcohol Addiction	Other ____________________________

Please circle either Yes or No to each question:		
Have you ever had any known contact with the AIDS virus?	Y N	*Describe*
Has any member of your family had diabetes?	Y N	*Describe*
Do your ankles swell during the day?	Y N	*Describe*
Have you had any weight changes lately?	Y N	*Describe*
Do you have any blood disorders such as anemia (thin blood, thalassemia)	Y N	*Describe*
Have you ever had radiation treatment or chemotherapy?	Y N	*Describe*
Have you ever had an injury, surgery or x-ray therapy to your face or jaw?	Y N	*Describe*
Do you have frequent earaches, ear/throat infections or hearing difficulties?	Y N	*Describe*
Is your eyesight: Good Adequate Poor Do you wear contact lenses?	Y N	*Describe*
Are you on a special diet?	Y N	*Describe*
Have you ever fainted?	Y N	*Describe*
Do you ever experience shortness of breath or chest pain when walking or climbing stairs?	Y N	*Describe*
Have you had any organ transplants or medical implants?	Y N	*Describe*
Do you have any disease, condition or problem that you think the doctor should know about?	Y N	*Describe*
Is there anything about yourself that we should be made aware of?	Y N	*Describe*
Have you ever been diagnosed or treated for Osteoporosis or Osteopenia?	Y N	*Describe*
Have you ever taken any of these medications		

Etdronate (Didronel)	Y N	Ibandronate (Boniva)	Y N
Tiludronate (Skelid)	Y N	Pamidronate (Aredia)	Y N
Alendronate (Fosamax)	Y N	Zoledronate (Zometa)	Y N
Risedronate (Actonel)	Y N		

Have you ever received chemotherapy treatment (IV or oral)?	Y N	*Describe*

FEMALE PATIENT INFORMATION (Adult)

Are you pregnant?	Y N	If yes, which month are you in?		Name of Obstetrician
Are you Taking Birth Control Pills	Y N	*If yes, Describe*		
Have you ever been diagnosed or treated for multiple myeloma or breast cancer?	Y N	*Describe*		

If you answered Yes to any of the above questions, please provide the following information:

Name and phone number of your Primary Physician ____________________________ Phone ________________________________

Name and phone number of your Specialist ____________________________ Phone ________________________________

MALE PATIENT INFORMATION (Adult)

Have you ever been diagnosed or treated for multiple myeloma or prostate cancer?	Y N	Describe

If you answered Yes to any of the above questions, please provide the following information:

Name and phone number of your Primary Physician ____________________________ Phone ________________________________

Name and phone number of your Specialist ____________________________ Phone ________________________________

DENTAL HISTORY

Is there a dental problem you would like to have taken care of as soon as possible?		Y N	Describe				
How frequently do you see your dentist (circle one)		3 months	6 months		Yearly	Other	
Name of former dentist			Last dental visit				
Have you been given oral hygiene instruction in brushing?		Y N	Flossing?	Y N			
Brushing (circle one)	Vigorous		Light		How often?	Type of brush	
How often do you floss?							
Other cleaning aids used:	Stimudents	Y N	Toothpick	Y N	Other		
Are any of your teeth sensitive to:	Cold	Y N	Sweets	Y N	Other		
Do your gums bleed when:	Brushing	Y N	Flossing	Y N	Spontaneous	Y N	

Have you ever had or do you now have any of the following? (please circle)

Bridges	Lost Fillings	Bite Appliance/Night Guard
Partial Denture	Extractions	Swelling or pain in your mouth or jaws
Gag easily	Full Dentures	Loose Teeth
Root Canals	Orthodontic Treatment	Injury to face or jaw
Gum Treatments	Difficulty opening or closing jaw	

Do you chew on only one side of your mouth?	Y N	*Describe*				
Does any part of your mouth hurt when clenched?	Y N	*Describe*				
Does your jaw crack or pop when opened widely?	Y N	*Describe*				
Do you have any pain in your ears?	Y N	*Describe*				
Have you experienced any growths or sore spots in your mouth?	Y N	*Describe*				
Do you grind or clench your teeth during the night or day?	Y N	*Describe*				
Do you mouth breathe while awake or asleep?	Y N	*Describe*				
Do you bite your lips or cheeks regularly?	Y N	*Describe*				
Do you hold any foreign objects with your teeth? (pipe, pencils, nails)	Y N	*Describe*				
Do you smoke?	Y N	(circle if yes)	cigarettes	cigars	pipe	other	No. Per day _______

Circle any of the following that you are interested in:

Orthodontics	Repairing chipped teeth	Improved gum health	Bonding
Bleaching	Improving your bite	Closing spaces	Crowns
Improving breath odour	Replacing missing teeth	Sport mouth guard	Improving your smile

How did you find out about our office? (circle one)

Person's Name   Drive By   Welcome Wagon   Phone Book   Advertisement   Website

*****We would greatly appreciate a notice of at least 2 full business days if you need to make changes to your appointments.*****