Boisson Dental Group

Rooted in the Peace

212, 11601-101 Ave Grande Prairie
AB, T8V 3X9
Email: info@boissondental.ca
Phone: (587) 771-7668

New Patient Registration and Medical History

Patient Name: ________________ ________________ ______ ________________
Last First MI Preferred Name

Date of Birth: ____________ Address: ____

Email: ____________________________ Home Telephone No: ____________________

Cell No: _______________ Patient Gender: ☐ Male ☐ Female

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ Pre-Medication	☐ Allergy - See Notes	☐ Allergy - Aspirin
☐ Allergy - Codeine	☐ Allergy - Iodine	☐ Allergy - Latex
☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Allergy - Erythromicin
☐ Allergy - Local Anesthesia	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Blood Disease
☐ Cancer	☐ Contraceptive Use	☐ Diabetes
☐ Dizziness / Fainting	☐ Emphysema	☐ Epilepsy
☐ Excessive Bleeding	☐ Excessive Bruising	☐ Gastro - Intestinal
☐ Glaucoma	☐ Hard To Freeze	☐ Hay Fever
☐ Head Injury	☐ Hearing Disabled	☐ Heart Disease

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- [ ] Heart Murmur
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] High Blood Pressure
- [ ] HIV+ (AIDS)
- [ ] Hives
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Mental Disorders
- [ ] Multiple Sclerosis
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Rheumatoid Arthritis
- [ ] Sinus Problems
- [ ] Skin Rash
- [ ] STD
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid Disease
- [ ] TMJ
- [ ] Tubercolosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Wheel Chair

Ever been hospitalized (illness or injury): ☐ Yes ☐ No

Presently being treated for any other illnesses: ☐ Yes ☐ No

Subject to frequent headaches: ☐ Yes ☐ No

Tobacco / Alcohol Use: ☐ Yes ☐ No

Female: Taking birth control pills: ☐ Yes ☐ No

Female: Pregnant: ☐ Yes ☐ No

If any conditions or alerts selected above need further clarification, please describe below:

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Do you take antibiotic premedication for your dental visits? If yes, please explain.

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and phone number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications (prescription and non-prescription) including regular doses of aspirin:

☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Patient Signature: _________________

Response Date: _______________