PATIENT REGISTRATION AND MEDICAL HISTORY

In order to evaluate your dental health thoroughly, please complete the following questionnaire. Successful therapy in addition to your safety depends upon knowing all factors or drug interaction which may be contributing to the management and treatment of your oral condition.

Last Name ☐ **First Name** ☐

What would you prefer to be called? ☐

Sex: Male ☐ **Female** ☐ **Status: Married** ☐ **Child** ☐ **Single** ☐ **Other** ☐

Birth Date: Day_________ Month _________ Year ___________

Employer

☐

Home Phone #:________________**Work Phone #:**______________**Cell Phone#:** _______________

Email Address: ____

Address: Street

☐

City ☐ **Province** ☐ **Postal Code** ☐

Name of General Dentist: __________________________________ **Phone #:** _________________

Name of Physician: ____**Phone #:** _________________

In case of emergency, please notify: __________________________**Phone #:** _________________

Primary Dental Insurance:

Name of Insured: _________________________ Place of Employment: ______________________
Insurance Carrier: _________________________ Group or Policy #: _________________________
Certificate or I.D. #: __________________ Div#: _______Dependent #: _____ Coverage % A_____
Birthdate of Plan Holder D/M/Y ________________Yearly Limits: ________Deductible___________

Secondary Dental Insurance:

Name of Insured: _________________________ Place of Employment: _______________________
Insurance Carrier: _________________________ Group or Policy #: __________________________
Certificate or I.D. #: __________________ Div#: _______Dependent #: _____ Coverage % A____
Birthdate of Plan Holder D/M/Y ________________Yearly Limits: ________Deductible___________

* We will submit claims and preauthorizations to your insurance company on your behalf but please be aware you are financially responsible for your dental treatment. Some insurance carriers may not reimburse specialist fees.

Patient's Name: ____________________ MEDICAL HISTORY

Email:____

Are you under a physician's care for a current condition? If yes, why …………………… Yes No
____

Are you taking medicines or non-prescription drugs of any kind?……………………… Yes No
Drug:___________________________ For: ____________________________
Drug:___________________________ For: ____________________________
Drug:___________________________ For: ____________________________
Drug:___________________________ For: ____________________________

Do you have any **allergies** to any medications?………………………………………… Yes No
____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

Aids/HIV
Anemia
Angina Pain
Arthritis
Artificial Heart Valve
Asthma
Bleeding Issues
Blood Transfusion
Bruise Easily
Cancer
Chemotherapy
Cold Sores
Cortisone Medication
Diabetes

Drug Addiction
Emphysema
Epilepsy
Glaucoma
Heart Issues –Please Describe
____
____
Hepatitis A (infectious)
Hepatitis B (serum)
High Blood Pressure
Low Blood Pressure
Joint Replacement
Kidney Disease
Liver Disease

Multiple Sclerosis
Osteoporosis
Pain in Jaw Joints
Pneumonia
Psychiatric Treatment
Rheumatic Fever
Seizures
Sinus Trouble
Skin Problems
Thyroid Disease
Tuberculosis
Ulcers
Yellow Jaundice

Do you have any disease, condition or problem not listed? ____________________ Yes No

Do you smoke? If yes, how much?______________________________________ Yes No

Are you having pain or discomfort at this time?……………………………………….. Yes No

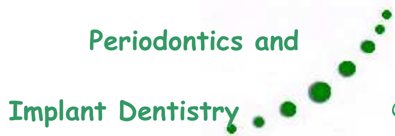
Have you found yourself grinding or clenching?……………………………………… Yes No

Do you feel very nervous about dental treatment?…………………………………….. Yes No

Have you ever had periodontal or gum treatment?……………………………………. Yes No

Women: Are you pregnant now?…………………………………………………… Yes No
Are you taking any birth control pill?……………………………………….. Yes No

______________________________ ________________________
Signature of Patient, Parent or Guardian Date



DR. TODD JONES **DMD, Dipl. Perio. FCDS**

Certified Specialist in Periodontics

NEW PATIENT
PRIVACY, DISCLOSURE, & CONSENT

TO: Dr. Todd Jones and Jones Health Services

Information for our Patients
At Dr. Todd Jones, all professional dental services are performed by licensed members of the British Columbia Dental Association and College ("Dental Professionals"), and all institutional health care services are performed independently by Jones Health Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Dr. Todd Jones and Jones Health Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in Jones Health Services.

Privacy Act and Consent to Treatment
By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for Dr. Todd Jones; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of Dr. Todd Jones to provide the services you are requesting.

Acknowledgement regarding Information Provided
I, the undersigned, certify that I have provided an 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 regarding my medical – dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office**. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that 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 authorize the exchange of my personal information among Dr. Todd Jones, Jones Health Services, my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by Dr. Todd Jones and Jones Health Services in accordance with their current practices, which may involve transfer and retention outside of Canada. I, the undersigned, acknowledge that the Dr. Todd Jones and Jones Health Services are relying upon the information which I have provided being accurate and complete.

______________________________________ ______________________________________ _____________

Print Name of ☐Patient ☐Parent ☐ Guardian Signature of ☐Patient ☐Parent ☐ Guardian Date

______________________________ _____________

Reviewed by Dr. Todd Jones Date

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