Dr. Karmveer (Karm)Panaich
Dr. Gurleen Panaich
Dr. Harprit (Hap) Kler

New Patient Registration

Name _____ _____
First Last Preferred Name

Address: _____ City: _____

Prov: _____ Postal Code: _____ Date of birth (dd/mm/yyyy):_____ Sex: M F

Phone Number: Home: _____ Cell_____ Best contact method: _____

Email: _____ Personal Health Number: _____

In case of Emergency Contact Name: _____Phone number:_____

Do you have Dental Insurance? Y N Employer: _____ Occupation: _____

How did you hear about our office: _____

Dental History

Please circle or mark the correct response and provide additional information where indicated.

Are you having pain at this time? Y N _____
Have you ever had complications related to dental treatment? Y N _____
Do you have any dental implants? Y N _____
Are you aware of any loose teeth? Y N _____
Does food tend to get caught between your teeth? Y N _____
Are you satisfied with the appearance of your teeth? Y N _____
Are you nervous about having dental treatment? Y N

Are any of your teeth sensitive to: cold ❑ sweets ❑ heat ❑ other ❑ N/A ❑

Do your gums bleed when: Brushing ❑ Flossing ❑ N/A ❑

Have you ever had any of the following: Oral Surgery ❑ Periodontal Treatment ❑

Orthodontic Treatment ❑ Bite Adjustment ❑ Night Guard ❑ Other Appliance: _____

Health History

Please fill out the following information to the best of your abilities.

Physician's Name: _____Phone Number: _____

Are you allergic, or have you reacted adversely, to any of the following?

Aspirin	____	Codeine	_____	Clindamycin	_____
Darvon	____	Demerol	_____	Erythromycin	_____
Latex	____	Local Anesthetic	_____	Mint Flavoring	_____
Penicillin	____	Sulfa Drugs	_____	NSAIDs	_____
		Taking Blood Thinners? ____		Have a pacemaker? _____	

Any Allergies Not listed: _____

Please list all medication you are taking now, including non-prescription medication (vitamins, cold medications, aspirin, Tylenol, antihistamines, herbal remedies, etc.): _____

_____

Do you have/or have you experienced any of the following:
Please fill out Yes or No on the line

AIDS/HIV	____	Diabetes	____	Mitral Valve Prolapse	____
Allergies/Hay Fever	____	Drug Addiction	____	Multiple Sclerosis	____
Anemia	____	Eating Disorder	____	Parkinson's Disease	____
Angina	____	Emphysema	____	Psychiatric Disorder	____
Angioplasty Pacemaker	____	Epilepsy	____	Rheumatic Fever	____
Artificial Joints	____	Glaucoma	____	Scarlet Fever	____
Arthritis	____	Heart Murmur	____	STD's	____
Asthma	____	Hepatitis A/B/C	____	Stroke	____
Blood Transfusion	____	Hemophilia	____	Tuberculosis	____
Cold Sores	____	High Blood Pressure	____	Ulcers	____
Chronic Fatigue Syndrome	____	Kidney Disease	____	Ulcerative Colitis	____
Congestive Heart Failure	____	Liver Disease	____	Artificial Heart Valve/Stent	____
	____	Lung Disease	____	Cardiopulmonary Shunt	____
		Lupus	____		

Do you have any disease, condition or problem not listed? _____
Do you wish to speak privately to the doctor about any medical condition? _____
Have you had a medical examination in the last year? _____
Have you been a patient in the hospital in the last 2 years? _____
Have you had Cancer? _____ if yes, location_____
Did you complete Radiation or Chemo Therapy? _____ if yes, when _____
When walking, do you ever stop because of pain in your chest? _____
Have you suffered from a Heart Attack? _____ if yes, when: _____
Do your ankles swell during the day? _____
Do you have a tendency to faint? _____
Do you have frequent, severe headaches? _____ Frequency? _____
Do you use tobacco? _____ How Much? _____
Are you pregnant or possibly pregnant? _____
Are you breastfeeding? _____

I, the undersigned, hereby certify that all the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status. I understand that it will be kept strictly confidential. I consent to the performing of the dental procedures to be necessary or advisable including the use of local anaesthetics. I am also aware that although this office has agreed to deal with my dental plan, any claims made on my behalf which have not paid become my responsibility.

Our office requires 48 hour notice to cancel or reschedule an appointment otherwise a cancellation fee will be applied.

_____ _____ _____
Patient Name (Print) Patient/Guardian Signature Date (dd/mm/yyyy)