CoolAid
everyone deserves home

PATIENT REGISTRATION

Legal First Name: _____ **Chosen Name:** _____

Legal Last Name: _____ **Birthday:** _____

Pronouns: They/Them She/Her He/Him Other: _____

Address: _____

City & Province: _____ **Postal Code:** _____

Primary #: _____ **Secondary #:** _____

Email: _____

Health Card # (PHN): _____ **Ministry/PWD insurance?** Yes No

First Nations Status #: _____

Private Insurance Provider: _____

Subscriber ID: _____ **Policy Number:** _____

Emergency Contact: _____ **Relation:** _____

Phone #: _____ **Email:** _____

Are you fluent in English? Yes No **Other Languages?** _____

Do you have hearing, vision, cognitive, or mobility impairments? If so, please describe below:

_____

How do you feel at the dentist and during dental work? Good Neutral Stressed Scared

Is there something we can do to help you feel comfortable here? If so, please describe below:

_____

General Release

I, the undersigned, understand that the information contained in the patient registration and health history documents are important to my treatment. I certify that all of the information I have given is correct and that I have not knowingly omitted any data. I consent to the release of plan and coverage information from my dental insurance provider. I consent to the release of medical information from my medical doctors and other health care providers as required by this office. I authorize this office to perform diagnostic procedures as may be required to determine recommended and necessary treatment.

Signature: _____ **Date:** _____

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Reviewed with Patient ☐

MEDICAL HISTORY

Name: _____ **Date of Birth:** _____

Do you have a family doctor? Yes No **Are you a patient of Cool Aid Health Clinic?** Yes No

Doctor Name: _____ **Clinic Name:** _____

Yes No **Do you see medical specialists?** (heart doctor, etc.) _____

Yes No **Do you take prescriptions? Pharmacy and Location:** _____

Yes No **Do you take vitamins or supplements?** _____

Yes No **Do you have any allergies?**

Latex ☐ Morphine ☐ Penicillin ☐ Erythromycin ☐ Sulfa Drugs ☐ Codeine ☐ Dairy ☐

Acetaminophen (Tylenol) ☐ Aspirin/Ibuprofen (Advil) ☐ Local Anesthetic (Freezing) ☐ Metals ☐

Others: _____

Yes No **Are you currently or could you be pregnant? Due Date:** _____

Yes No **Are you breastfeeding?**

Yes No **Have you been hospitalized or had any surgeries within the last five years?**

Reason and date of hospitalization: _____

Reason and date of hospitalization: _____

Yes No **Do you have any transmissible diseases?**

HIV/AIDS ☐ HIV - undetectable ☐ Hepatitis C - treated ☐ Hepatitis C - untreated ☐ Syphilis ☐

Oral Herpes/Cold Sores ☐ Hepatitis A/B ☐ Scabies/Bed Bugs ☐ Other: _____

Yes No **Do you have heart problems or conditions?**

High Blood Pressure ☐ Heart Attack ☐ Angina ☐ Stroke ☐ Heart Murmur ☐ Endocarditis ☐

Heart Failure ☐ Others: _____

Describe: _____

Yes No **Have you ever had heart surgery?**

Describe: _____

Yes No **Do you take blood thinners or have clotting problems?**

Describe: _____

Yes No **Do you have lung problems or conditions?** (asthma, COPD, oxygen therapy, etc.)

Describe: _____

Yes No **Do you have any bone or muscle problems or conditions?** (arthritis, osteoporosis, etc.)

Describe: _____

Yes No **Have you had any joint replacements?**

Describe: _____

Signature: _____ **Date:** _____

Yes No **Do you have any digestive, liver, or kidney problems or conditions?**

Ulcers ☐ Reflux ☐ IBD ☐ IBS ☐ Liver Disease ☐ Kidney Disease ☐ On Dialysis ☐ Other ☐

Describe: _____

Yes No **Do you have any autoimmune problems or conditions?**

Rheumatoid Arthritis ☐ Crohn's ☐ Parkinson's ☐ Fibromyalgia ☐ Other ☐

Describe: _____

Yes No **Do you have any hormone or thyroid problems or conditions?**

Hypothyroid ☐ Hyperthyroid ☐ Surgery ☐ Other ☐

Describe: _____

Yes No **Do you have any neurological or developmental conditions?**

Alzheimer's ☐ Dementia ☐ Epilepsy ☐ ADD/ADHD ☐ Autism ☐ Other ☐

Describe: _____

Yes No **Do you have any mental health problems or conditions?**

Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Schizophrenia ☐ OCD ☐ PTSD ☐ Other ☐

Describe: _____

Yes No **Do you have diabetes?** Type I Type II

Yes No **Do you currently, or have you ever had cancer?**

Describe: _____

Yes No **Do you have any other medical conditions/diagnoses:**

Describe: _____

Yes No **Do you smoke, vape, or use tobacco/nicotine?**

Describe type, and frequency: _____

Yes No **Do you use any substances?**

* We ask because some substances can **fatally interact** with dental treatment. *

Meth/Side ☐ Cocaine/Crack ☐ Heroin/Down ☐ Fentanyl/Opiates ☐ Ketamine ☐ Inhalants ☐

Alcohol ☐ Cannabis/Marijuana ☐ Prescription Medication Not Prescribed to You ☐ Other ☐

Describe: _____

Yes No **Do you have dry mouth during the day or night?** Describe: _____

When was the last time you went to the dentist? _____

What do you do to take care of your teeth? How frequently? (for example: I brush and floss twice daily)

_____

_____

Signature: _____ **Date:** _____