

Nova Dental Care

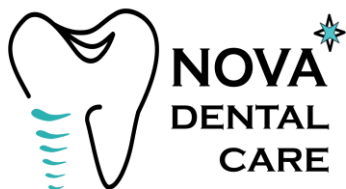
Unit 220, 4620 Bow Trail SW, Calgary, AB, T3C 2G6

(587) 885 – 3898

www.novadentalcare.ca

NEW PATIENT REGISTRATION FORM

Date:		
PATIENT INFORMATION		
Last Name:		First Name:
Preferred Name:		
Address:		Postal Code:
Date of Birth:	AB/Provincial Health Card NO:	
Gender:		
CONTACT INFORMATION:		
Home #		Email Address:
Cell #		
Work #		
Mailing Address:		
Billing Address (if different from Mailing address):		
Emergency Contact:		
Emergency Contact Phone #		
INSURANCE		
Do you have dental Insurance Coverage:		
If Yes , please specify insurance company/provider:		
ID Number:	Group/ Policy Number:	
Primary insured member's name (if different from patient):		
Primary Insured Date of Birth (if different from patient):		
Relationship to the Patient:		
Is the treatment due to an accident:		
If Yes , Date of Accident:		
Explain:		
ALLERGIES: (PLEASE SELECT ALL THAT APPLY)		
<input type="checkbox"/> Acetaminophen/ Tylenol	<input type="checkbox"/> Acrylic	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Demerol	<input type="checkbox"/> Erythromycin
<input type="checkbox"/> Fluoride	<input type="checkbox"/> Food	<input type="checkbox"/> Hay Fever/ Seasonal
<input type="checkbox"/> Ibuprofen/ Motrin/Advil	<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex
<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Metals	<input type="checkbox"/> Morphine
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Pets	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Other (Please specify):	



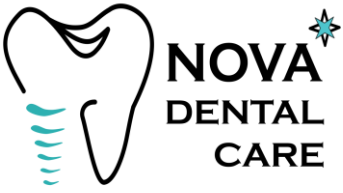
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Medical Conditions:		
<input type="checkbox"/> Abnormal/Excessive Bleeding	<input type="checkbox"/> AIDS or HIV Infection	<input type="checkbox"/> Alzheimer's/ Dementia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Angina	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Cancer/ Chemotherapy/ Radiation Treatment	<input type="checkbox"/> Cardiovascular Disease
<input type="checkbox"/> Chest Pains Upon Exertion	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Damaged Heart Valves	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Seizures	<input type="checkbox"/> Fear of Needles
<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Gastrointestinal Disease	<input type="checkbox"/> G.E Reflux/ Heartburn
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Gout	<input type="checkbox"/> Hard to Freeze
<input type="checkbox"/> Hearing Difficulties	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Heart Rhythm Disorder	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Jaundice or Leaver Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Joint Replacement
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Low Pain Tolerance
<input type="checkbox"/> Malnutrition	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Neurological Disorder
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Osteoporosis / Paget's Disease	<input type="checkbox"/> Congenital Heart Defects
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Persistent Swollen Glands in Neck	<input type="checkbox"/> Physical Challenges
<input type="checkbox"/> Pregnant/Nursing	<input type="checkbox"/> Pre-Medication	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Recurrent Infections	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Rheumatic Heart Disease
<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Severe Headaches/ Migraines
<input type="checkbox"/> Severe or Rapid Weight loss	<input type="checkbox"/> Sexually Transmitted Infection (STI)	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Stroke	<input type="checkbox"/> Systematic Lupus Erythematosus	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> TMJ Disorder	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Have you ever taken FosaMax [®] , Boniva [®] , Actonel [®] or other medications containing Bisphosphonates		<input type="checkbox"/> Do you Smoke/ Wear a Nicotine Patch
<input type="checkbox"/> Ulcers	<input type="checkbox"/> other:	



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Medications (please list):

Patient Signature: _____ Date: _____