North Burnaby Dental Group

INFORMATION AND HEALTH HISTORY

For our office records we would appreciate the following information. All information will be kept confidential and an opportunity will be provided to discuss everything later. Thank you very much for your cooperation.

Mr. Mrs. Miss Ms. _____ Date _____

Street _____ Date of birth _____

City and postal code _____ Home phone _____

Email address _____ Cell phone _____

Employer _____ Work phone _____

Work address _____

Spouse _____ Spouse's cell ph _____

Spouse's employer _____ Spouse's work ph _____

How did you hear about our office?

Referred by: _____ ❑ Website ❑ Internet ❑ Newspaper ❑ Flyer ❑ Walk by

Person responsible for account: ❑ Self ❑ Spouse ❑ Insurance ❑ Other

Primary dental insurance

Dental plans vary greatly. The forms, conditions and percentages of payments are contracted between you, your employer and the insurance company. It is your responsibility as the insurance holder to know your plan and inform us of any changes that may occur. Our office will bill your dental insurance company directly for their portion of your treatment charges. You will be required to pay the patient portion on each visit.

Subscriber's name _____ Subscriber's date of birth _____

Employer's name _____ Insurance co. _____

Group number _____ Identification no. _____

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DENTAL HEALTH QUESTIONNAIRE

To help ensure your wellbeing while receiving treatment in our office, please answer the following questions. All information will be considered confidential and for our records only.

1. Have you been examined by a physician within the last year? Yes ❑ No ❑
2. Have you ever been seriously ill or hospitalized? Yes ❑ No ❑
3. Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma? Yes ❑ No ❑
4. Are you taking any medication or non-prescription drugs now? Yes ❑ No ❑

   If yes, what? _____
5. Have you any complaints concerning your teeth we can help you with? Yes ❑ No ❑

   If yes, please elaborate _____
6. Family Doctor _____ Phone# _____

Please mark (X) if you have or have had any of the following:

Specific

❑ Rheumatic fever
❑ Heart murmur
❑ Congenital heart condition
❑ Arteriosclerosis
❑ Stroke
❑ Angina pectoris
❑ Blood pressure problems
❑ Heart trouble
❑ Lung / breathing problems
❑ Kidney / bladder problems
❑ Stomach / intestinal problems
❑ Hepatitis
❑ Liver disease
❑ Diabetes
❑ Blood disorder
❑ Pacemaker / artificial valves
❑ Artificial joints / implants
❑ Infectious / communicable
❑ Veneral disease
❑ Tested positive for HIV/AIDS
❑ Nervous / mental problems
❑ Epilepsy
❑ Thyroid disease
❑ Arthritis
❑ Inflammatory rheumatism
❑ Cortisone / steroid therapy

Sensititivies / Allergies

❑ Hives / skin rash
❑ Asthma
❑ Hay fever
❑ Allergies
❑ Unusual reaction to any drugs

Systems review

❑ Prolonged bleeding after injury
❑ Bruise easily
❑ High risk group for AIDS
❑ Severe headaches
❑ Sinus trouble
❑ Ear aches
❑ Trouble hearing
❑ Swollen ankles
❑ Shortness of breath
❑ Heart palpitations
❑ Persistent cough
❑ Blood in sputum
❑ Vomiting
❑ Feel thirsty much of the time
❑ History of family disease

Habits

❑ Tobacco
❑ Alcoholic beverages
❑ Drugs

Women only / Are you:—

❑ Pregnant
❑ Menopausal

Is there anything else concerning your health that you think the doctor should know about?

_____

_____

Signature _____ Date _____