Burnaby Mountain Dental Centre

We are pleased to welcome you to our practice, please take a few minutes to fill out this form as completely as you can.

PATIENT INFORMATION

First Name: _____ Last Name: _____

Email: _____ Phone: _____ ☐ Mobile ☐ Home

Date of Birth: _____ Gender: _____

Address: _____ City: _____

_____ Province: _____ Postal Code _____

Status: ☐ Child ☐ Single ☐ Married

EMPLOYMENT INFORMATION

Employed by _____ Occupation _____

Whom may thank for referring you? _____

In case of emergency who should be notified?

Name: _____ Phone#: _____ Relationship: _____

INSURANCE INFORMATION

Group Number: _____

Insurance Carrier: _____ ID Number: _____

MEDICAL HISTORY

Family Doctor's Name: _____ Date of Last Visit: _____

Have you had any serious illness or operation?: ☐ Yes ☐ No

If yes, describe: _____

Have you ever had a blood transfusion? Yes No If yes, give approximate date: _____

Have you ever experienced abnormal bleeding associated with previous extraction, surgery, or trauma?: ☐ Yes ☐ No

List medications you are currently taking: _____

Are you allergic to any medication?: _____

Have you had any unusual reaction to any drugs? (if so what drug): _____

Do you smoke?: ☐ Yes ☐ No Do you Drink?: ☐ Yes ☐ No Do you take non-prescription drug?: ☐ Yes ☐ No

Check if you have or have had any of the following:

- ☐ Lung/Breathing Problems/Asthma
- ☐ Congenital Heart Condition
- ☐ Blood Pressure Problems
- ☐ Kidney/bladder problems
- ☐ Stomach/Intestinal Problems
- ☐ Hepatitis/Jaundice/Liver Disease
- ☐ Pacemaker/artificial valves
- ☐ Nervous/Mental Problems
- ☐ Inflammatory Rheumatism
- ☐ Severe Headaches/Migraines
- ☐ Prolonged Bleeding after Injury
- ☐ Frequent indigestion/vomiting
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Blood Disorder
- ☐ Thyroid Disease
- ☐ Hives/Skin Rash
- ☐ Sinus problems
- ☐ Trouble hearing
- ☐ Swollen ankles
- ☐ Persistent cough
- ☐ Tendency to faint
- ☐ Recent change in appetite
- ☐ Cancer
- ☐ Stroke
- ☐ Diabetes
- ☐ AIDS
- ☐ Earaches
- ☐ Epilepsy
- ☐ Arthritis
- ☐ Hay Fever
- ☐ Bruise Easily
- ☐ Sore throat
- ☐ Difficulty in swallowing

Women only: Are pregnant?: ☐ Yes ☐ No Nursing?: ☐ Yes ☐ No Past Menopause?: ☐ Yes ☐ No

DENTAL HISTORY

Reason for Visit: _____ Date of last dental visit: _____

Check if you have or have had any of the following:

- ☐ Sensitivity to hot/cold
- ☐ Ortho treatment
- ☐ Clicking or popping jaw
- ☐ Broken/lost fillings
- ☐ Extractions
- ☐ Root Canal Treatment
- ☐ Sensitivity when biting
- ☐ Food between teeth
- ☐ Dentures (full/partial)
- ☐ Sore/lumps in your mouth
- ☐ Injury to face/jaw
- ☐ Bleeding gums
- ☐ Gum treatment
- ☐ Grinding teeth
- ☐ Loose teeth
- ☐ Bridges
- ☐ Bad Breath

How often do you floss?: _____ How often do you brush?: _____

Are you satisfied with the function and appearance of your teeth?: _____

***

*I understand that payment is due in full at time of treatment unless prior arrangements have been approved. I understand that cancellations or rescheduling must be done 48hrs prior or a $50 fee will be charged to my account. ****

Full Name:

_____ Signature: _____ Date: _____

(If patient is a child, parent signature is needed)