PATIENT INFORMATION (*CONFIDENTIAL*)

NAME _____ DATE _____

ADDRESS_____ POSTAL CODE_____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EMPLOYER _____

CARE CARD NUMBER _____ EMAIL ADDRESS _____

DATE OF BIRTH _____ AGE ___ SEX M / F MARITAL STATUS _____

SPOUSE OR PARENT=S NAME _____ EMPLOYER _____

EMERGENCY CONTACT _____ PHONE _____

IF STUDENT, NAME OF SCHOOL _____ GRADE _____

IS THIS YOUR FIRST DENTAL VISIT THIS CALENDAR YEAR? Y / N DO YOU HAVE DENTAL INSURANCE? Y / N

WHOM MAY WE THANK FOR REFERRING YOU _____

MEDICAL HISTORY

1) HAS YOUR HEALTH CHANGED RECENTLY?

_____

2) PHYSICIANS NAME _____

3) DATE OF LAST MEDICAL EXAM _____

4) PLEASE LIST ANY HOSPITALIZATIONS

_____

_____

5) PLEASE LIST ALL MEDICATIONS YOU ARE TAKING:

_____

_____

6) ARE YOU PREGNANT OR NURSING? _____

7) PLEASE LIST ANY ALLERGIES TO MEDICATIONS:

_____

_____

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE OR HAVE HAD:

RHEUMATIC HEART DISEASE OR FEVER

HEART DEFECT / MURMUR

CHEST PAIN / SHORTNESS OF BREATH

PACEMAKER

HIGH BLOOD PRESSURE

HEPATITIS

STROKE

LUNG PROBLEMS / ASTHMA

HIVES OR SKIN RASH

FAINTING OR DIZZY SPELLS

DIABETES

AIDS OR HIV

THYROID PROBLEMS

ARTHRITIS OR RHEUMATISM

JOINT REPLACEMENT OR IMPLANT

KIDNEY PROBLEMS

TUBERCULOSIS / PERSISTNET COUGH

SEXUALLY TRANSMITTED DISEASES

EPILEPSY OR SEIZURES

TUMORS/ CHEMOTHERAPY

MITRAL VALVE PROLAPSE

CORTISONE TREATMENT

HYPOGLYCEMIA

EATING DISORDERS

BRUISE OR BLEED EASILY

PAST BLOOD TRANSFUSION
SMOKER / ALCOHOLIC

IV DRUG USE

AUTHORIZATION AND RELEASE

1) I certify that I have read and understand the information on this form to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

2) I authorize the release of any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners submitted electronically and otherwise.

3) I understand that Dr. Braun and Dr. Sollid follow the fee guide determined by the College of Dental Surgeons of B.C. However, I understand my dental insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

4) I understand that I am responsible for ensuring my dental insurance is in effect on the date of my treatment, and for knowing conditions and limits of my insurance. I understand that Drs. Braun and Sollid make every attempt to understand my insurance, but cannot be held responsible for any non-payments which occur as a result of these conditions and limits.

4) I understand that payment is due on the day of service and that any overdue accounts will be charged a monthly interest charge of 3%.

5) I understand that appointments missed or cancelled with less than 24 hours notice will be charged a missed appointment fee.

_____ **DATE:** _____

SIGNATURE OF PATIENT OR GUARDIAN

MEDICAL UPDATES

DATE_____**UPDATE**_____

_____**Signature**_____

DATE_____**UPDATE**_____

_____**Signature**_____

DATE_____**UPDATE**_____

_____**Signature**_____