

PATIENT PERSONAL INFORMATION

Patient Last Name: _____	Patient Address: _____
Patient First Name: _____	_____
Patient Middle Initial: _____	City: _____
Title: Mr. Mrs. Miss Master Ms. _____	Prov: _____ Postal Code _____
Marital Status: M _____ S _____ C.L. _____	If Child - Parents Name: _____
Spouse or Partners Name: _____	Sex: M _____ F _____ Policy Holder Yes _____ No _____
Res. phone #: _____	Policy Holders Name: _____
Bus. phone #: _____ Ext. _____	Policy Holders Date of Birth.: _____
S.I.N.: _____	Policy Holders S.I.N. _____
Birthdate: Month _____ Date _____ Year _____	Name of Employer: _____
Name of Physician : _____	Insurance Company _____
Who may we thank for referring you?	Group # _____
Person: _____ Yellow Pages _____	Details of coverage _____
Staff: _____ Other : _____	Basic _____ Crown & Bridge _____
Have you seen a dentist this year? _____	Ortho _____
Yes _____ Who? _____ No _____	Is there a deductible? Yes _____ No _____
If yes, what was done: _____	

Care Card No. _____	

**NOTE: IF YOUR INSURANCE COMPANY WILL NOT PAY FOR A PROCEDURE THE RESPONSIBILITY IS YOURS.
THE INSURANCE CONTRACT IS BETWEEN THE INSURED PATIENT AND THE INSURANCE COMPANY, NOT THE
DENTIST AND THE INSURANCE COMPANY.**

PATIENT MEDICAL HISTORY

	yes	no
1. Are you now under the care of a physician? What is the condition being treated? _____		
2. Have you had any serious illness or operation? If yes, what was the illness or operation? _____		
3. Have you ever been hospitalized? If yes, what was the problem? _____		
4. Are you taking any drug or medicine including birth control pills? If yes, what? _____		
5. Do you use tobacco products? Yes () No () Cigarettes? _____ No. per day _____ Pipe _____ Snuff _____ Have you tried to eliminate these products from your life? _____		
6. Are you allergic to or have you reacted adversely to any drug or medicine: eg. local anaesthetic (freezing), penicillin or other antibiotics, barbituates, sedatives, analgesics (pain killers)? _____ If so what? _____		
7. Do you have any of the following? a. Rheumatic fever or rheumatic heart disease _____ b. Birth defects in the heart _____ c. Heart attack, high blood pressure, hardening of the arteries, stroke _____ d. Chest pains or shortness of breath _____ e. Asthma, hay fever or skin rash _____ f. Fainting spells or seizures (epilepsy) _____ g. Diabetes _____ h. Kidney disease _____ i. Hepatitis, jaundice or liver disease _____ j. Thyroid disorder _____ k. Lung or breathing disorder _____ l. Stomach/bowel problem _____ m. Nervous disorder _____ n. Bone, muscle or joint disorders: eg. arthritis _____ o. Cancer _____ p. Aids or ARC HIV Positive _____		
8. Have you ever had abnormal bleeding associated with previous extractions, surgery or cuts?		
9. Do you have any blood disorder? _____		
10. Women, are you pregnant? _____		
11. Do you have, or have you had any eating disorder eg. anorexia or bulimia? _____		
12. Do you have any disease or disorder not listed that you think I should know about? If yes, what? _____		

TREATMENT CONSENT

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable and will assume responsibility for the fees associated with those procedures.

Signature of patient (parent, quardian) _____ Date _____

Dr. Paul Collard

Vanderhoof Dental Health Centre
Box 1322 140 West Victoria St. Vanderhoof, B.C.
Phone 250-567-9226 Toll free 1-877-250-567-9226

Instructions for Parents or Caregivers of Patients referred for General Anesthetic

The patient will be required to attend Dr. Collard's office - Vanderhoof Dental Health Centre- with the primary caregiver to jointly develop a treatment plan.

You are required to pay \$100.00 before the appointment with the hospital is made. This is not covered by any dental plan and is non-refundable.

The patient will be required to see the Doctor that is doing the anesthetic, at Omenica Medical Clinic, on the day before the general anesthetic. Our office will book this appointment for you approximately one week before the G.A. and will call you with the time and date.

Omenica Clinic, St. John Hospital and Vanderhoof Dental Health Center