VANCOUVER ISLAND PROSTHODONTICS

CERTIFIED SPECIALISTS IN PROSTHODONTICS

Name: _____ **Birthdate:**_____
M D Y

BC Care Card #_____

Address:_____

City:_____ **Postal Code:**_____

Home Phone:_____ **Work Phone:**_____

Email:_____

Occupation:_____

Family Dentist:_____

Family Physician:_____

Referred by:_____

In order to prevent any misunderstanding about dental insurance, we wish to inform you that we will provide a professional courtesy of submitting claims to your insurance company. However you should be aware that you are responsible for the payment of the total fees for your treatment and your insurance company will reimburse you the amount covered under your plan.

Insurance Company:_____ **Insurance Company:**_____

Policy Holder:_____ **Policy Holder:**_____

Policy Holder's Birthdate:_____ **Policy Holder's Birthdate:**_____

Employer Name:_____ **Employer Name:**_____

Group #:_____ **Group #:**_____

ID#:_____ **ID#:**_____

Name: _____

Date: _____

Dental History:

1. What is your present dental complaint?

   _____

2. Are you in pain or discomfort at this time? Y N
3. Are you extremely nervous about dental treatment? Y N
4. Have you had previous periodontal treatment? Y N
5. Last cleaning? _____
6. Are your gums: Swollen? Bleeding? Sore?
7. Are your teeth: Sensitive? Loose? Sore?
8. Do you grind your teeth? Y N
9. Are you missing any teeth? Y N Reason: Cavities? Gum disease?
10. Have you ever had orthodontic treatment (braces)? Y N

Medical History:

1. Have you been treated by a physician or been admitted to a hospital during the past 2 years? If so, what for?

   _____

2. Please list any serious illnesses, surgeries or infections you may have had:

   _____

   _____

3. Please list any medications you are taking presently or took during the past year:

   _____

   _____

4. Have you had an adverse reaction to the following:

   Penicillin Codeine Latex
   Aspirin Dental Anesthetic Other: _____

5. Have you been on any steroid/ cortisone treatment in the past year? Y N
6. Do you smoke? N Y How much? _____

7. Circle any of the following which you have had or have at present:

Heart attack	Asthma	COPD
Angina	Bronchitis	Hepatitis A--B--C
Valvular Disease	Tuberculosis	Jaundice
Valve replacement	Chronic cough	Blood transfusions
Bacterial Endocarditis	Circulation problems	Radiation Therapy
Congenital defects	Stroke	Chemotherapy
Bypass surgery	Splenectomy	HIV/ AIDS
Rheumatic Fever	Bruise easily	MS
High blood pressure	Anemia	Diabetes
Pacemaker	Hemophilia	Kidney Disease
Swollen ankles	Glaucoma	STDs
Epilepsy	Cancer/Tumour	Fainting
Psychiatric treatment	Thyroid Disease	Rheumatism
Arthritis	Osteoporosis	Immunosuppressed

8. Unexplained weight gain or loss in the past year? Y N
9. Are you on a special diet? Y N

   If so, what?_____

10. Do you have any disease, condition or problem not listed? Y N

    If so, what?_____

11. Women: Are you pregnant now? Y N
12. Is there any possibility of being pregnant? Y N

I, the undersigned, certify that all of the medical information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary, as this may be required for my dental care.

Signature:_____

Date:_____