Commercial Station Dental Centre

#211 – 2460 Commercial Drive, Vancouver, B.C., V5N 4B9
Phone# 604-708-6111 Fax# 604-708-6112

Mr. / Mrs. / Ms. / Miss (Please Circle)

Last Name _____ **First Name** _____ **Birth date** *mm/dd/yyyy* **Sex** ___

Address _____ **City** _____ **Postal Code** _____

Phone: (Home) _____ **(Mobile)** _____ **(Other)** _____

Email Address _____ **How often do you check your e-mail?** _____

Family Doctor _____ **Phone #** _____ **Care Card #** _____

Do you have dental insurance? Yes / No **Insurance company** _____ **Last dentist visit?** _____

Dentist:_____ **Phone of dentist** _____ **SIN #** _____

How did you find us? _____

Medical History

	Yes	No
1. Are you under any medical treatment?	☐	☐
2. Are you taking any medications? If yes, please list: _____	☐	☐
3. Are you allergic to Penicillin, Erythromycin, Sulfa or other drugs? If yes, please list: _____	☐	☐
4. Do you have any other allergies? If yes, please list: _____	☐	☐
5. Have you ever bled abnormally before?	☐	☐
6. Have you ever had any surgery? When and why? _____	☐	☐
7. Have you ever been a patient in a hospital? When and why? _____	☐	☐
8. Have you had any serious illness? If yes, please list: _____	☐	☐
9. Have you been advised to take antibiotic prophylaxis before dental treatment?	☐	☐
10. Do you smoke now or before? How often? _____	☐	☐
11. Do you vape or use e-cigarettes? How often? _____	☐	☐
12. Do you use any recreational substances (eg. Marijuana)? How often? _____	☐	☐

	Yes	No
13. Are you aware of any grinding or clenching?	☐	☐
14. Are you mainly a nose or mouth breather? _____		
15. (For women) Are you pregnant now or planning to?	☐	☐
16. Do you have frequent headaches?	☐	☐
17. Do you still have your wisdom teeth?	☐	☐
18. Have you ever had orthodontic (braces) treatment? Are you interested? Yes / No	☐	☐
19. Can you think of any reason you shouldn't receive dental treatment at this time? Why not? _____	☐	☐

20. **Is there any other information you would like to add?**

_____

_____

Do you have a history of, or ever suffered from the following? Please only tick those that apply.

☐ Heart problems	☐ Heart murmur	☐ High blood pressure	☐ Tuberculosis
☐ Diabetes	☐ Kidney disease	☐ Liver disease	☐ Jaundice
☐ Hepatitis	☐ Blood transfusion	☐ Venereal disease	☐ Anemia
☐ Asthma	☐ Epilepsy	☐ Thyroid disease	☐ Stomach problems, ulcers, acid reflux
☐ Stroke	☐ Sinusitis	☐ Rheumatoid or osteoarthritis	☐ Syncope or fainting spells
☐ Psychiatric conditions	☐ Cold sores		

Patient's Acknowledgement

I have read the terms and conditions, and completed this questionnaire to the best of my knowledge. I acknowledge that I am financially responsible for fees incurred from the services I receive, including fees not fully covered by my dental plan and/or fees that have exceeded the limit imposed by my dental plan coverage. I understand I am liable to pay a $100 fee per hour for appointment cancellations of less than 2 working days.

Signature of patient/guardian _____ **Date** *mm/dd/yyyy*