BC PERIO

DENTAL HEALTH & IMPLANT CENTRE

WWW.BCPERIO.CA

Name (Ms.Mrs.Mr.Dr.)_____ Date of Birth_____

Surname Given Name dd/mm/yy

Address_____ Postal Code _____

Street City

Home No._____ Cellular No._____ Business No. _____

Best Time to Call_____ Gender _____ Marital Status_____

Email Address_____ Referred By_____

Occupation_____ Emergency Contact_____ Phone No._____

Family Doctor_____ Date of Last Visit_____ Family Dentist Dr. Lu

Dental Insurance info: Carrier Name_____ Group # _____ ID #_____

Second Carrier is applicable: Carrier Name_____ Group # _____ ID #_____

1. What is the reason for your Dental visit today?_____

2. If you could change anything about your mouth, teeth or smile, what would it be? _____

_____

_____

3. Please list any medications, non-prescription drugs, or herbal remedies/vitamins you are currently taking:

_____

4. Please list any general allergies or drug allergies you have experienced (eg. Penicillin, Aspirin, Codeine, Sulfa, etc):

_____

_____

5. Please check all of the following that apply to you:

☐ Asthma	☐ Pregnant	☐ Heart Condition	☐ Diabetes	☐ Blood Condition
☐ Bone Disease	☐ Cancer	☐ Tuberculosis	☐ Hepatitis	☐ Bleeding Issues
☐ Kidney Disease	☐ Epilepsy	☐ Prosthetic Joints	☐ Headaches	☐ High Blood Pressure

6. How much do you smoke per day? (Check one) ☐ N/A ☐ <10/day ☐ <1 Pack/day ☐ >1 Pack/day

7. Do you have any other health issues or medical/dental concerns? (Eg. Fainting easily, Menopause, etc.) Please List/Explain:

_____

_____

I hereby certify that I have read and understand the above information and it is accurate to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information may be hazardous to my health, and affect my overall treatment outcome.

_____ _____/_____/_____

Signature of patient, parent/guardian Day Month Year