BC PERIO
DENTAL HEALTH & IMPLANT CENTRE

Name (Ms.Mrs.Mr.Dr.) _____ Date of Birth_____
Surname Given Name dd/mm/yy

Address_____ Postal Code_____
Street City

Gender_____ E-mail Address_____

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

Occupation:_____ Referred by_____ How did you hear about us? _____

Emergency Contact Name: _____ Relationship:_____ Phone No._____

Family Doctor_____ Family Dentist_____ Dentist Phone No:_____

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

Secondary Carrier if applicable: Carrier Name:_____ Group # _____ ID # _____

Secondary Plan Holder Name: _____ Secondary plan Holder Birthdate_____
dd/mm/yy

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 circle 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? (Circle 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. I acknowledge the CT Scan taken at BC Perio is intended for use at BC Perio, for treatments provided by BC Perio. A $350 duplicating fee will be applied to any copies requested by the patient for use outside BC Perio office.

_____ _____/_____/_____
Signature of patient, parent/guardian Day Month Year