WE WELCOME YOU TO OUR OFFICE

Dr. Natalee Peeters D.M.D, Dr. Kristopher Bouwmeester D.M.D and Dr. Jasmeen Dhaliwal D.M.D

Patient Information

________________________ ___________________________ ______ Birthday ____/____/____ M ☐ F ☐

Surname First Mid. Initial DD/MM/YY

____

Mailing Address City Postal Code

____

Home # Work # Cell # E-mail

____ ____

Employer/Occupation BC Medical Number

*Whom may we thank for referring you to our office? ____

Spouse/Common Law Information (If Applicable)

________________________ ___________________________ _______ Birthday ____/____/____ M ☐ F ☐

Surname First Initial DD/MM/YY

If Patient Is A Minor

________________________ ___________________________ _______ Birthday ____/____/____

Mother's/Father's Surname First Initial DD/MM/YY

________________________ ___________________________

Cell Work

________________________ ___________________________ _______ Birthday ____/____/____

Father's/Mother's Surname First Initial DD/MM/YY

________________________ ___________________________

Cell Work

I hereby authorize dental services for ____________________________ Signature _________________________

Office Policies

We respect that your time is valuable and we request that you respect our time as well. If you book an appointment please attend it. We require at least **two** business days notice for changes. A fee may be charged for short notice cancellations or missed appointments.

For patients with dental insurance:

Claims for dental services will be sent to dental insurance companies, providing coverage is in effect at time of dental services. Payment of patient's portion is due at the time of the appointment. It is your, the patient's, responsibility to know your insurance financial and procedure limits. Please be aware of your coverage because we cannot accept responsibility for amounts not covered by insurance policies.

For patients without dental insurance:

Payment is due at the time service is provided.

____ ____

Signature Date

Medical History

Name of physician ____Date of last visit ______________________

Do you have any general health problems?____

____

Drug allergies / other allergies or sensitivities ____

Women: Are you pregnant? Yes ☐ No ☐ If yes, due date? ____

Please list all medications, herbal supplements or vitamins

Name of drug	Dosage	Reason

Have you ever had any of the following (tick box and note details or circle if applicable):

Rheumatic fever ________________ ☐

Heart disease / Heart murmur ____ ☐

High / Low blood pressure ________ ☐

Anemia / Blood disorders _________ ☐

Excessive bleeding after surgery ___ ☐

Thyroid problems _______________ ☐

Kidney disease __________________ ☐

Diabetes (type I, II) _______________ ☐

Arthritis_________________________ ☐

Hip / Knee replacement ___________ ☐

Fainting, dizziness, convulsions, epilepsy______________________ ☐

Physical / mental disabilities ________________________________ ☐

Asthma / Emphysema / T.B/COPD____________________________ ☐

Cancer / Radiation therapy _________________________________ ☐

Any contagious or communicable disease ____________________ ☐

Hepatitis (A, B, C) – If so, when _____________________________ ☐

Acquired Immune Deficiency Syndrome (AIDS, HIV)_____________ ☐

Back / Neck problems ____________________________________ ☐

Malignant hyperthermia ___________________________________ ☐

Hospital Surgery ____ ☐

History of smoking / chewing tobacco? Please indicate amount and for how long ________________________

Medical comments / concerns____

Dental History

Previous Dentist ________________________________ ________________________________ Date of Last Exam

	YES	NO
Are you presently in any dental discomfort	☐	☐
Have you had regular check-ups	☐	☐
Are you aware of clenching / grinding	☐	☐
Bad breath / Taste / Bleeding gums	☐	☐
Sensitivity to hot, cold or sweets	☐	☐
Bite pressure	☐	☐
Do you wear partial / complete dentures	☐	☐

Do you have any problems with:	YES	NO
TMJ (jaw joint) clicking / popping / discomfort	☐	☐
Are you pleased with the appearance of your teeth	☐	☐
Do you have rough / broken fillings	☐	☐
Do you or your child experience anxiety about dental treatment?	☐	☐

Do you have any special concerns? ____