Broadway Family Dental Centre
383 East Broadway Vancouver, BC V5T 1W6
604-283-2216

PATIENT INFORMATION

First Name:_____ **Last Name:**_____ **Birthdate(D/M/Y):**_____

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

Home Phone:_____ **Cell Phone:**_____ **Email:**_____

INSURANCE INFORMATION

Primary Insurance Plan

Holder's Full Name:_____ **Birthdate(D/M/Y):**_____

Name of Insurance Company:_____ **Group/Plan#**_____ **Certificate/ID#**_____

Secondary Insurance Plan

Holder's Full Name:_____ **Birthdate(D/M/Y):**_____

Name of Insurance Company:_____ **Group/Plan#**_____ **Certificate/ID#**_____

MEDICAL / DENTAL HISTORY

Date of last dental visit:_____ **Date of last X-rays:**_____ **Name of previous Dentist:**_____

Have you ever had any reactions to dental freezing? YES_____NO_____ If yes, please explain:_____

If female, are you pregnant? YES_____ NO_____ Possibly:_____

Please check if you have ever been treated for:

_____Heart troubles or Stroke	_____Thyroid Disease	_____Cancer
_____Tuberculosis or Lung Disease	_____Blood Disorder	_____Jaundice
_____Mental or Nervous Disease	_____Kidney Disease	_____Asthma
_____Stomach or Intestinal Ulcers	_____Diabetes	_____Epilepsy
_____Hepatitis or Liver Disease	_____Injury to Face	_____A.I.D.S
_____Rheumatic Fever	_____High Blood Pressure	_____Do you grind?
_____Arthritis or Rheumatism	_____Growth or Tumor	_____Do you snore?

Allergies:_____

Prescribed Medication:_____

Is there anything that the Dentist should know regarding your medical status or health that has not been mentioned?

_____

Who may we thank for this referral?_____

This is to certify that I, the undersigned, consent to the performing of the dental and / or oral surgery procedures, agreed necessary or advisable, including oral anaesthetic sedation as indicated, and I will assume responsibility for all fees associated with these procedures.

Patient/Parent signature:_____ **Date:**_____