PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DR. MARCY SCHWARTZMAN INC.
DR. SHARLENE TABATA
DR. LORI DURWARD

OAKRIDGE CENTRE, SOUTH BUILDING; 305 - 650 WEST 41st AVENUE
VANCOUVER, BC V5Z 2M9

IF THIS APPOINTMENT IS FOR YOU START HERE

TODAY'S DATE			1
NAME			
YOUR SPOUSE'S NAME			
ADDRESS			
CITY	PROVINCE	POSTAL CODE	
HOME PHONE NO.		WORK PHONE NO.	
EMAIL	CELL PHONE NO.		
BIRTHDATE YR MONTH DAY		AGE	
MARRIED	SINGLE	DIVORCED	WIDOWED

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
NAME			
ADDRESS			
CITY	PROVINCE	POSTAL CODE	
HOME PHONE NO.		PARENT WORK PHONE NO.	
BIRTHDATE	AGE		GRADE

IF YOUR CHILD'S NAME AND ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE ABOVE BOX ALSO.

DENTAL INSURANCE	2
PRIMARY CARRIER	
INSURANCE COMPANY	
NAME OF INSURED	
BIRTHDATE OF INSURED YR MONTH DAY	
ID #	
COVERAGE % A. B. C. D.	
EMPLOYER'S NAME	
GROUP NO.	
LIMITS	DEDUCTIBLE
SECONDARY CARRIER	
INSURANCE COMPANY	
NAME OF INSURED	
BIRTHDATE OF INSURED YR MONTH DAY	
ID #	
COVERAGE % A. B. C. D.	
EMPLOYER'S NAME	
GROUP NO.	
LIMITS	

ACCOUNT INFORMATION	4
YOUR EMPLOYMENT INFORMATION	
NAME OF EMPLOYER	
OCCUPATION	
BUSINESS ADDRESS	CITY
PHONE NUMBER	EXT.
YOUR SPOUSE'S EMPLOYMENT INFORMATION	
NAME OF EMPLOYER	
OCCUPATION	
BUSINESS ADDRESS	CITY
PHONE NUMBER	EXT.

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

I understand that I am financially responsible for all dental services provided in this office for myself and my dependents.

Signature _____

Date: _____

48 HOURS NOTICE IS NECESSARY IF YOU NEED TO RESCHEDULE AN APPOINTMENT; OTHERWISE THERE MAY BE A FEE.

GETTING TO KNOW YOU	3
IS ANOTHER MEMBER OF YOUR FAMILY, OR A RELATIVE A PATIENT AT OUR OFFICE? YES ☐ NO ☐ THEIR NAME:	
REFERRED TO US BY	
PERSON TO CONTACT FOR EMERGENCY	
PHONE NUMBER	
CLOSEST RELATIVE NOT LIVING WITH YOU	
PHONE NUMBER	
ADDRESS	
CITY PROVINCE	POSTAL CODE

C291702164

PLEASE TURN OVER

HEALTH HISTORY

The data on this confidential questionnaire is essential to render the best professional care. We appreciate your co-operation in filling it out carefully so that we will have accurate records.

CIRCLE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
5. Have you been under the care of a medical doctor for any condition in the last 2 years? ..... YES NO

   Physician's Name _____

   Phone Number _____
6. Have you taken any medicine or drugs during the past two years? ..... YES NO

   Are you now taking any medication, drugs or pills? ..... YES NO

   If yes, please list: _____
7. Are you allergic or have you reacted adversely to any of the following medications? ..... YES NO

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Darvon	Erythromycin	Scopolamine	(Novocain or Xylocaine)
Codeine	Tetracycline	Penicillin	Sleeping Pills
Demerol	Percodan	Other antibiotics	(Nembutal/Seconal)

8. Are you aware of being allergic to any other medications or substance? ..... YES NO

   If yes, please list: _____
9. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	A.I.D.S.	Osteoporosis
Heart Disease or Attack	Cough	Hepatitis A (infectious)	
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)	
High Blood Pressure	Asthma	Liver disease	
Heart Murmur	Hay Fever	Yellow Jaundice	
Rheumatic Fever	Sinus Trouble	Blood Transfusion	
Congenital Heart Lesions	Allergies or Hives	Drug Addiction	
Scarlet Fever	Diabetes	Hemophilia	
Artificial Heart Valve	Thyroid Disease	Venereal Disease (Syphilis, Gonorrhea)	
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores	
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Fever Blisters	
Artificial Joints (Hip, Knee)	Arthritis	Epilepsy or Seizures	
Anemia	Rheumatism	Fainting or Dizzy Spells	
Stroke	Cortisone Medicine	Nervousness	
Kidney Trouble	Glaucoma	Psychiatric Treatment	
Ulcers	Pain in Jaw Joints	Sickle Cell Disease	
Cosmetic Surgery	Smoke	Bruise Easily	

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
11. Do your ankles swell during the day? ..... YES NO
12. Do you use more than 2 pillows to sleep? ..... YES NO
13. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
14. Do you ever wake up from sleep short of breath? ..... YES NO
15. Are you on a special diet? ..... YES NO
16. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
17. Do you have any disease, condition, or problem not listed? ..... YES NO

FOR WOMEN ONLY

Are you pregnant? ☐ YES ☐ NO If yes, what month? _____. Are you taking birth control pills? ..... YES NO

CONSENT:

The undersigned verifies that the above information is true and authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor and Patient to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, once I have been informed of my choices, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as she deems fit. I also understand the use of anesthetic agents embodies a certain risk.

Patient and/or Responsible Party _____ Date _____ Witness _____