

PATIENT REGISTRATION AND HEALTH HISTORY
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

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

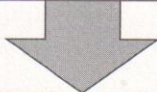
OAKRIDGE CENTRE, SOUTH BUILDING; 305 - 650 WEST 41st AVENUE
VANCOUVER, BC V5Z 2M9

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		AGE	
YR	MONTH	DAY	
MARRIED	SINGLE	DIVORCED	WIDOWED
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.			

IF THIS
APPOINTMENT IS
FOR YOUR CHILD
START HERE

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 <input type="checkbox"/> NO <input type="checkbox"/>		
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

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.

HEALTH HISTORY

- 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 _____