Aberdeen Dental Clinic
Welcomes you!

PERSONAL INFORMATION

Last name:	**First Name:**	
Preferred Name:		Male / Female
Address:		
City	Postal Code	
Tel: Home	Work	Cellular
Birth Day	Month	Year
Email:	**Marital Status:** Single Married Child Other	
Referred by:		

HEALTH AND DENTAL HISTORY

1. Current medications: ______
2. Have you been told by physician to take antibiotics before regular dental treatment? YES NO
3. Do you have frequent severe headaches? YES NO
4. Do you smoke or use any tobacco products? YES NO
5. WOMEN ONLY – Are you pregnant? If so, how many months? ______ YES NO
6. Are you allergic or have you reacted adversely to any of the following medications? (Please circle)

Aspirin	Codeine	Iodine	Latex
Penicillin	Sulfa	Erythromicin	Local Anesthetic

Others ______

7. Have you had any of the following? (Please circle)

Anemia	Arthritis	Artificial Joints	Asthma
Blood Disease	Cancer	Diabetes	Dizziness/Fainting
Emphysema	Epilepsy	Excessive Bleeding	Excessive Bruising
Gastro-Intestinal	Hay Fever	High/Low Blood Pressure	Head Injury
Hearing Disability	Heart Disease	Heart Murmur	Hepatitis A/B/C
HIV/AIDS	Jaundice	Kidney Disease	Liver Disease
Mental Disorder	Nervous Disorder	Pacemaker	Radiation Treatment
Respiratory Problems	Rheumatic Fever	Rheumatism	Rheumatoid Arthritis
Sinus Problems	Skin Rash	Stomach Problems	Stroke
Thyroid Disease	Tuberculosis	Tumors	Ulcer
STD (Sexually Transmitted Disease)		TMD (Temperomandibular Joint Disorder)	

Others ______

8. Have you ever had any injury, surgery, or radiation therapy to your face or jaws? YES NO
   Please specify: ______
9. Do you have any concerns about your breath, the colour and appearance of your teeth, or the health of your teeth and gums? YES NO
   Please explain: ______
10. Do you have any oral habits? (Please circle) Clenching Grinding Nail biting
11. Please list any condition or problem not listed above that you think the doctor should know about:
    ______
12. When and where was your last dental examination? ______
    When and where was your last dental cleaning? ______

Consent

This is to certify that I, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated and I will assume responsibility for fees associate with those procedures.

Patient's/ Guardian's Signature: ______ Date: ______

Please also be advised that, on the recommendation of the B.C. College of Dental Surgeons, Aberdeen Dental accepts assignment of benefits from dental insurance only as a courtesy to our valued patients. Patients, with or without insurance coverage, are solely responsible for all expenses incurred from treatment in our office, and payment is expected upon delivery of service.

INSURANCE (Please allow us to complete this section with you.)

PRIMARY INSURANCE

1. Insurance is provided through: (select one)

a. Employer Company Name: Tel: b. Spouse c. Parent

d. Other (specify relationship) Name: Birthdate

2. Insurance Company Name	**3. Group No.**	**4. ID No.**
5. Benefit Year: Calendar Other	**6. Current Fee Guide:** Yes No	**7. Deductible:** Individual $ Family $
8. Insurance pays dentist? Yes No		**9. Electronic Claim?** Yes No
10. Basic % Limit $	**11. Major** % Limit $	**12. Ortho** % Limit $
Recall :	**Polish :**	**Fluoride :**
Comp Exam :	**Scale :** **RP:**	**Sealant :** YES / NO
Complete Series 02102 :	**Pan :**	**BW :**
Specialist : YES / NO		**Composite on Molar :** YES / NO
Last Recall 01202 :		**Last Pan 02601 :**

13. I authorize release to my insuring company plan administrator, the information contained in claims submitted electronically:

Signature of patient or parent/guardian

I hereby assign my benefits payable from claims submitted electronically to Aberdeen Dental Centre on behalf of our doctors and authorize payment directly to them:

Signature of subscriber

SECONDARY INSURANCE

1. Insurance is provided through: (select one)

a. Employer Company Name: Tel: b. Spouse c. Parent

d. Other (specify relationship) Name: Birthdate

2. Insurance Company Name	**3. Group No.**	**4. ID No.**
5. Benefit Year: Calendar Other	**6. Current Fee Guide:** Yes No	**7. Deductible:** Individual $ Family $
8. Insurance pays dentist? Yes No		**9. Electronic Claim?** Yes No
10. Basic % Limit $	**11. Major** % Limit $	**12. Ortho** % Limit $
Recall :	**Polish :**	**Fluoride :**
Comp Exam :	**Scale :** **RP:**	**Sealant :** YES / NO
Complete Series 02102 :	**Pan :**	**BW :**
Specialist : YES / NO		**Composite on Molar :** YES / NO
Last Recall 01202 :		**Last Pan 02601 :**

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