BURNABY FAMILY DENTAL
GENERAL . COSMETIC . IMPLANTS

#203 – 6411 Nelson Ave.
Burnaby, B.C., V5H 4H3
tel: 604-437-5222
email: info@burnabyfamilydental.com
www.burnabyfamilydental.com

Thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care. To help us meet all your dental care needs, please fill out this form completely. If you have any questions or need assistance please ask us – we will be happy to help.

Date:_____ (D/M/Y)

Patient Information (Confidential)

Name: _____ (Mr/Mrs/Ms First Middle Last) Birthdate:_____ (D/M/Y)
Gender: ☐M ☐F Family Status: ☐ Minor ☐ Single ☐ Married ☐ Other
Home Phone:_____ Work Phone:_____ (EXT)
Mobile:_____ Email: _____
Address:_____ (Apt No Street No Street Name PO. Box) City:_____ Prov:_____ Postal Code_____

Spouse or Responsible Party Information

The following is for: ☐ Patient Spouse ☐ Person responsible for payment ☐ Neither
Name: _____ (Mr/Mrs/Ms First Middle Last) Birthdate:_____ (D/M/Y)
Gender: ☐M ☐F Family Status: ☐ Minor ☐ Single ☐ Married ☐ Other
Home Phone:_____ Work Phone:_____ (EXT) Mobile:_____
Address:_____ (Apt No Street No Street Name PO. Box) City:_____ Prov:_____ Postal Code_____

INSURANCE INFORMATION (Primary)

Name: _____ (First Middle Last)
Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Name of Insurer:_____
Group Policy #:_____ ID #:_____

Do you have additional Coverage from anothe insurer?: ☐ Yes ☐ No

INSURANCE INFORMATION (Secondary)

Name: _____ (First Middle Last)
Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Name of Insurer:_____
Group Policy #:_____ ID #:_____

Medical History

Who can we thank for referring you to our office?:_____
When was your last medical check up?:_____
Within the last year have you been diagnosed or treated for any medical condition? ☐ No ☐ Yes
If yes explain:_____

Has there been any change in your general health in the past year? If yes please explain: ☐ No ☐ Yes
If yes explain:_____

Please list medications, non-prescription drugs or herbal supplements of any kind that you are taking:

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Medical History (Continued)

Do you have any allergies? eg. medications, latex, hayfever, foods?: ☐ No ☐ Yes
If yes explain:_____
Have you ever had a peculiar or adverse reaction to any medicines or injections?: ☐ No ☐ Yes
If yes explain:_____
Have you ever been hospitalized for any illness or operations? ☐ No ☐ Yes
If yes explain:_____
Do you or have you ever had chest pain, angina?:
If yes explain:_____
Are there any diseases or medical problems that run in your family?: ☐ No ☐ Yes
If yes explain:_____
Are there any diseases or medical problems that run in your family?: ☐ No ☐ Yes
If yes explain:_____

_____

_____

Have you ever had a heart attack or stroke?: ☐ No ☐ Yes
If yes explain:_____
Do you or have you ever had Cancer?: ☐ No ☐ Yes
If yes explain:_____
Are you on or have you ever been on Steroid Therapy or on Diet Pill Therapy?: ☐ No ☐ Yes
If yes explain:_____
Do you suffer from or have you ever had seizures (epilepsy)?: ☐ No ☐ Yes
If yes explain:_____
Do you or have you ever had Thyroid or Kidney Disease: ☐ No ☐ Yes
If yes explain:_____
Do you or have you ever had a dependency on drugs or alcohol: ☐ No ☐ Yes
If yes explain:_____

Please check all that apply:

Do you have or have you ever had asthma?	☐ No	☐ Yes
Do you have or have you had blood pressure problems?	☐ No	☐ Yes
	☐ High	☐ Low
Do you have or have you had a heart murmur, mitral valve prolapse or rheumatic fever?	☐ No	☐ Yes
Do you have a prosthetic or artificial joint?	☐ No	☐ Yes
Have you ever been advised by your Doctor to take antibiotics before dental treatment?	☐ No	☐ Yes
Do you have any conditions/therapies that could affect your immune system?	☐ No	☐ Yes
Have you ever had a hepatitis, jaundice or liver disease?	☐ No	☐ Yes
Do you have a bleeding problem or bleeding disorder?	☐ No	☐ Yes
Do you smoke or chew tobacco?	☐ No	☐ Yes
Do you suffer from shortness of breath?	☐ No	☐ Yes
Do you have a prosthetic heart valve of pace maker?	☐ No	☐ Yes
Do you or have you ever had tuberculosis?	☐ No	☐ Yes
Do you or have you ever had Diabetes?	☐ No	☐ Yes
Do you or have you ever had stomach ulcers?	☐ No	☐ Yes
you or have you ever had arthritis?	☐ No	☐ Yes