SMILEDENTAL 49
Caring Smile of All Ages

DENTAL FORM

PERSONAL INFORMATION

Full Name : _____

Birthdate : _____ / _____ / _____

Address : _____ **City** : _____

Province : _____ **Postal Code** : _____

Phone Number : _____ **E-Mail** : _____

Cell Number : _____ **Work Number** : _____

NOTE: Please be aware of any limitations to your plan since responsibility for your account belongs to you. Our staff will gladly handle your insurance details

Who may we thank for referring you : _____

HEALTH HISTORY:

1. Have you been under the care of a medical doctor during the past two years? Yes_____ No_____
Physician's Name :_____ Phone Number :_____
2. Have you ever been hospitalized? Yes_____ No_____
3. Have you ever had any serious illness or operation? Yes_____ No_____
4. Have you taken any medicine or drugs during the past two years? Are you now taking any medication, drugs, or pills?
Yes_____ No_____

5. Are you allergic or have you reacted adversely to any of the following medications?

Aspirin	Nitrous Oxide	Valium	local Anesthetic
Darvon	Erythromycin	Sulfonamide (sulfa)	Clindamycin
Codeine	Tetracycline	Penicillin	Sleeping Pills
Demerol	Percodan	Other Antibiotics	lobuprofen

6. Circle any of the following which you have had or have at present:

Rheumatic fever	Stroke	Artificial joints	Frequent headaches
Congenital heart disease	Prolonged bleeding	Allergies	Vision problems
Heart murmur	Blood transfusions	Cancer	Cosmetic surgery
Heart attack	Diabetes	Radiation / Chemotherapy	Sinus problems
Congestive heart failure	Thyroid	AIDS/ HIV	Hay fever
Pacemaker, artificial valves or transplants	Hepatitis	Cold Sores	Drug addiction
Heart Surgery	Kidney problem	Venereal disease	Cortisone medication
Tuberculosis	Stomach ulcers	Fainting spells	Sickle cell disease
High or low blood pressure	Digestive problems	Epilepsy disorders	Scarlet fever
	Arthritis	Nervous disorders	Asthma

7. Do you Smoke? Yes_____ No_____
8. Are you allergic to latex gloves? Yes_____ No_____
9. Women Only:
Are you Pregnant? Yes_____ No_____
If yes, What Month? _____
Are you taking birth control? Yes_____ Please List_____ No_____

EMERGENCY CONTACT DETAILS

Contact Name : _____

Relationship : _____

Home Number : _____

Mobile Number : _____

More Information :
6425 Main Street Vancouver BC V5W 2V5
604 321 8001 (Office)
www.smiledental49.com
maindental177@yahoo.ca

THANK YOU

Dr. J Riar

Jatinder Riar

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DENTAL FORM

DENTAL INSURANCE INFORMATION (PRIMARY)

DENTAL INSURANCE INFORMATION			
PRIMARY DENTAL PLAN			
INSURANCE COMPANY			
EMPLOYER			
NAME OF INSURED			
ID#			
GROUP#			
D.0.8.			
COVERAGE%	A	B	C
LIMITS/ DEDUCTIBLES			
SECONDARY DENTAL PLAN			
INSURANCE COMPANY			
EMPLOYER			
NAME OF INSURED			
ID#			
GROUP#			
D.0.B.			
COVERAGE%	A	B	C
LIMITS/ DEDUCTIBLES			

PATIENT CERTIFICATION & PATIENT CONSENT:
I, the undersigned that all of the above medical information is true to my knowledge, and I have not omitted any pertinent information.
I, the undersigned hereby consent to take X-rays, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis.
I consent to the dental treatment agreed upon and also understand the use of anesthetic agents embodies a certain risk.
I understand that a possibility of complication exists for each treatment.
I understand that responsibility for payment for dental services rendered in this office is expected at the end of each appointment unless financial arrangements have been made.
Furthermore, I authorize release of information from my dental plan administrator and consent to electronic submission of my dental claims for the current and all subsequent dental treatment from this office.

Patient Signature_____ **Date:** _____

Dr. J Riar

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