#6 – 6305 120TH Street
Delta, BC V4E 2A6

**DELTA PERIO GROUP**
**PATIENT INFORMATION**

Tel: 604-590-5010
Fax: 604-590-2834

EMAIL – office@deltaperio.ca

Mr. Mrs. Miss Ms. Dr. _____
Last First

Address _____City _____Postal Code_____

E-mail Address_____ Birthdate _____/_____/_____
(Day) (Month) (Year)

Home Phone _____

Work Phone _____Occupation _____

Cell Phone _____ Referred by _____

Your General Dentist _____ Phone Number_____
(If Different from Referral)

Name of Spouse/Partner_____ Phone_____

Family Physician _____ Phone_____

Emergency contact _____ Phone _____

## DENTAL INSURANCE INFORMATION

**Primary Insurance**

Name of Insured_____

Relationship to Patient_____

Insured's Birthdate _____ (D/M/Y)

Employer_____

Insurance Co. _____

Group/Policy # _____

Certificate/ID# _____

% of Basic Coverage _____

**Secondary Insurance**

Name of Insured_____

Relationship to Patient_____

Insured's Birthdate _____

Employer_____

Insurance Co. _____

Group/Policy # _____

Certificate/ID# _____

% of Basic Coverage _____

___I am not covered by any Dental Insurance at this time

**Insurance:**
I authorize release, to my dental benefits plan administrator and CDA, information contained in claims submitted electronically, I also authorize the communication of information related to the coverage of services described to the named dentist.
I hereby assign my benefits, payable from claims submitted electronically, to Dr. Andrea Lynch and authorize payment directly to her (if applicable). Note – All examinations in our office are submitted electronically payable to the policy holder only.

**Cancellation Policy:**

There will be a charge of $250 if a surgical treatment appointment is canceled with less than 7 business days' notice. All other appointments require 2 business days' notice for any cancellation or change or a fee of $100 will be applied. Please remember this time is reserved exclusively for you. Your courtesy in doing this may allow someone else to be seen in a timelier manner.

I acknowledge that I have read and understand the above statements and policies and that this authorization remains valid and effective from the date of signing until revoked in writing.

_____ _____
Signature of Patient or Patient's Legal Guardian Date of Signature

# MEDICAL HISTORY

HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH (CIRCLE ONE): EXCELLENT GOOD FAIR POOR DON'T KNOW

**YES NO ???**

- ❑ ❑ ❑ HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?
- ❑ ❑ ❑ HAVE YOU HAD A SERIOUS ILLNESS, OPERATION OR HOSPITALIZATION IN THE PAST?
  IF YES, PLEASE DESCRIBE _____
- ❑ ❑ ❑ ARE YOU TAKING OR HAVE YOU RECENTLY TAKEN:
  PRESCRIBED MEDICATIONS_____
  OVER THE COUNTER, NATURAL OR HERBAL PREPARATIONS: _____
- ❑ ❑ ❑ ARE YOU TAKING OR HAVE YOU RECENTLY TAKEN BISPHOSPHONATES? E.G -AREDIA, ZOMETA, FOSAMAX OR ANY OTHERS
  ☐RECEIVED I.V., OR ☐TAKEN ORALLY _____
- ❑ ❑ ❑ HAS YOUR DOCTOR TOLD YOU TO TAKE ANTIBIOTICS PRIOR TO HAVING ANY TYPE OF DENTAL PROCEDURE?
- ❑ ❑ ❑ ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY DRUG OR MEDICINE: (E.G. IODINE, PENICILLIN, LATEX, LOCAL ANESTHETIC (FREEZING)), IF SO, PLEASE LIST THEM _____
- ❑ ❑ ❑ HAVE YOU EVER HAD EXCESSIVE BLEEDING THAT REQUIRED SPECIAL TREATMENT?
- ❑ ❑ ❑ HAVE YOU BEEN DIAGNOSED AS HAVING ANY IMMUNODEFICIENCY, SYSTEMIC LUPUS, ARC OR AIDS?
- ❑ ❑ ❑ IS THERE A HISTORY OF DIABETES IN YOUR FAMILY?
- ❑ ❑ ❑ ARE YOU REQUIRED, DUE TO HEALTH, TO RESTRICT YOUR WORK OR ACTIVITY IN ANY WAY?
- ❑ ❑ ❑ ARE YOU ON A SPECIAL OR RESTRICTED DIET OF ANY KIND? _____
- ❑ ❑ DO YOU USE ANY KIND OF TOBACCO? IF SO HOW MUCH: _____ PER DAY, WEEK, MONTH
- ❑ ❑ ❑ DO YOU HAVE ANY HISTORY OF SUBSTANCE ABUSE OR DO YOU CURRENTLY USE RECREATIONAL DRUGS?

FOR WOMEN, CHECK ALL THAT ARE APPROPRIATE: ❑ I AM PREGNANT ❑ I AM NURSING ❑ I AM TAKING BIRTH CONTROL PILLS

**CHECK ALL OF THE FOLLOWING THAT YOU MAY HAVE HAD IN THE PAST OR THAT CURRENTLY APPLY TO YOU:**

- ❑ CHEST PAIN UPON EXERTION
- ❑ SHORTNESS OF BREATH
- ❑ HIGH BLOOD PRESSURE
- ❑ LOW BLOOD PRESSURE
- ❑ HEART VALVE PROSTHESIS
- ❑ CONGENITAL HEART LESION
- ❑ HEART MURMUR
- ❑ DAMAGED HEART VALVE
- ❑ HEART SURGERY
- ❑ TACHYCARDIA
- ❑ CARDIAC PACEMAKER
- ❑ HEART ARRHYTHMIA
- ❑ ESOPHAGEAL REFLUX
- ❑ MITRAL VALVE PROLAPSE
- ❑ HIATAL HERNIA
- ❑ G.I. ULCERS
- ❑ ANOREXIA OR BULIMIA
- ❑ IRRITABLE BOWEL SYNDROME
- ❑ COLITIS
- ❑ RECENT WEIGHT LOSS
- ❑ IMPAIRED LIVER FUNCTION
- ❑ KIDNEY DISEASE
- ❑ IMPAIRED KIDNEY FUNCTION
- ❑ HEPATITIS OR JAUNDICE
- ❑ RECEIVED BLOOD TRANSFUSION
- ❑ RECURRENT INFECTIONS
- ❑ HISTORY OF CANCER
- ❑ RADIATION THERAPY
- ❑ CHEMOTHERAPY
- ❑ DIABETES
- ❑ OSTEOPOROSIS
- ❑ ARTHRITIS
- ❑ CONNECTIVE TISSUE DISORDER
- ❑ JOINT REPLACEMENT SURGERY
- ❑ GOUT
- ❑ NEUROLOGICAL DISORDERS
- ❑ MENTAL HEALTH PROBLEMS
- ❑ STROKE
- ❑ EPILEPSY
- ❑ SEIZURES
- ❑ RHEUMATIC FEVER
- ❑ PERSISTENT COUGH
- ❑ BRONCHITIS
- ❑ EMPHYSEMA
- ❑ TUBERCULOSIS
- ❑ ASTHMA
- ❑ SINUS TROUBLES
- ❑ MIGRAINES
- ❑ SEVERELY IMPAIRED VISION
- ❑ GLAUCOMA
- ❑ WEAR CONTACT LENSES
- ❑ SLEEP APNEA
- ❑ CHRONIC FATIGUE

**DO you have any disease, problem or condition not listed above? Please explain:** _____

_____

**I BELIEVE THE INFORMATION ON THIS FORM TO BE CORRECT AND PROVIDES A COMPLETE SUMMARY OF MY PAST OR PRESENT MEDICAL AND DENTAL STATUS.**

**I, THE UNDERSIGNED (PATIENT OR LEGALLY RESPONSIBLE PARTY), AUTHORIZE DENTAL TREATMENT TO BE RENDERED BY THE DENTIST AND STAFF, AND ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES NOT COVERED OR PAID TO THE DENTIST BY ANY THIRD PARTY CARRIER**

_____ _____ _____

**Signature of patient or legal guardian** **Date** **Reviewed by**