fine DENTISTRY
101-9840 Fifth Street
Sidney, BC V8L 2X3
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Patient Information

Patient Name: ______________________________Date of Birth: ___________
[ ] Mr. [ ] Mrs. [ ] Miss [ ] Ms
[ ] Dr [ ] Child [ ] Single [ ] Married Spouse's Name:____________________

Phone [Home]:__________ [Work]:__________[Cell]:__________________

Email Address: ____

You will be able to confirm your appointments via emails and automated text reminders

Home Address: ____

City:__________________Province:_________Postal Code:_______________

Employer Name: __________________________**Occupation:**_____________

Health Information

Have you ever had or have any of the following? Please check those that apply:

- AIDS
- Allergies:__________
  ____
  ____
  ____
- Anemia
- Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Cancer, type?
  ____
- Diabetes, type: ______
- Dizziness
- Epilepsy
- Excessive Bleeding,
- explain what caused it:__________
  ____
- Fainting
- Glaucoma
- Gum Disease
- Migraine Headaches
- Hay Fever
- Head Injuries
- Heart Disease
- Heart Murmur
- Hepatitis, type:______
- High Blood Pressure
- Lung Disease
- Kidney Disease
- Liver Disease
- Mental Disorders
- Nervous Disorders
- Oral Cancer or lesion
- Pacemaker
- Pregnancy {presently}
- Due Date:
  ____
- Radiation Treatment When?__________
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Stomach Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Tumors
- Ulcers
- Venereal Disease
- Codeine Allergy
- Penicillin Allergy
- Please list any other drug allergies not mentioned here:
  ____
  ____
  ____
  ____
  ____
  ____
- Is there anything not listed here concerning your medical history we need to know about?[ ] Yes [ ] No
- If yes, explain:
  ____
  ____
  ____
  ____

In the past 2 years, have you been to the hospital for surgery or emergencies? [ ]No [ ]Yes, explain:
____

What is the name and location of your family physician?______________________