YXE dental

Name: _____/_____/_____

Last name First name Preferred to be called

MEDICAL INFORMATION

Medical Doctor: _____ Telephone #: _____

Date of the last physical exam: _____

Do you take aspirin daily: _____ Dosage: _____

Do you smoke? _____ Amount per day: _____

Are you presently under the care of a medical doctor? If yes, regarding what?

_____

Have you had any artificial prosthesis? (Joints, heart valves, pacemaker)

_____

Have you had any serious illness/operations: _____

Women: Are you pregnant: _____ If yes, Due Date: _____

Medications you are currently taking: _____

HAVE YOU EVER TESTED POSITIVE FOR:

Hepatitis .....Yes/No
Circle: A, B, OR C

AIDS and/or HIV.....Yes/No
Tuberculosis.....Yes/No

UNFAVORABLE DRUG REACTIONS OR ALLERGIES TO:

Local Anesthetics (Freezing).....Yes/No
Penicillin.....Yes/No
Other Antibiotics.....Yes/No
(If yes, list antibiotic here: _____)

General Anesthetics.....Yes/No
Erythromycin.....Yes/No
Latex.....Yes/No
Asprin.....Yes/No

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THESE FOLLOWING CONDITIONS?

Anemia..... Yes/No
Arthritis..... Yes/No
Blood Disorder..... Yes/No
Chest Pain..... Yes/No
Diabetes..... Yes/No
Emphysema..... Yes/No
Epilepsy..... Yes/No
Heart Murmer..... Yes/ No
Migraine headaches..... Yes/No
Sinus Trouble..... Yes/No
Stomach Ulcers..... Yes/No
Thyroid Disease..... Yes/No

Asthma..... Yes/No
Cancer..... Yes/No
(Type of Cancer: _____ Diagnosed: _____)
Chemotherapy/Radiation..... Yes/No
Depression/Anxiety..... Yes/No
Fainting or Dizzy Spells..... Yes/No
Heart Disease..... Yes/No
High/low blood pressure..... Yes/No
Neurological disorder (eg. M.S, Parkinsons)..... Yes/No
Sleep Apnea..... Yes/No
Stroke..... Yes/No
Osteoporosis..... Yes/No

DENTAL HISTORY

- Have you been under regular care of a dentist? Yes/No
- How long since your last dental visit? _____
- Do your gums feel tender or swollen? Yes/No
- Do any of your teeth hurt or are loose? Yes/No
- Are you satisfied with the appearance of your teeth? Yes/No

Please explain if you answered no:

_____

PERSONAL INFORMATION

Mailing Address: _____

City: _____ Postal Code: _____

Home Phone#: _____ Work Phone #: _____ Cell Phone #: _____

Email Address: _____

Date of Birth (DD/MM/YEAR): _____

Saskatchewan Health Card: _____

Supplementary Health Coverage (If applicable) Yes/No

DIAN # (if applicable): _____

Employed by: _____ Occupation: _____

INSURANCE INFORMATION

- ○ No Insurance/Self Payment

Primary Insurance Information

Name of Insurance Holder: _____ Date of Birth: _____

Name of Insurance Company: _____

Policy #/Group #: _____

Certificate/ ID #: _____

Secondary Insurance Information

Name of Insurance Holder: _____ Date of Birth: _____

Name of Insurance Company: _____

Policy #/Group #: _____

Certificate/ ID #: _____

OUR OFFICE POLICY

I, _____ consent to the performing of any dental procedures agreed to be necessary or advisable by Dr. Hui, Kirkpatrick, Beaudry, and/or Kularatne as explained to me in my treatment plan. I understand that any further appointments I have at YXE Dental are Reserved just for me and if I am unable to keep my appointment I will give at least 24 hours notice. If I have to cancel my appointment with less than 24 hours notice it may be necessary for YXE Dental to charge me a fee.

Depending on the company of the insurance there maybe a difference in fees paid by my insurance company and those charged by YXE Dental. I understand that I am responsible for the total fees associated with any treatment I receive at YXE Dental, including any fees not covered by my insurance.

Date: _____

Patient/Parent/Guardian signature: _____

In case of an emergency, please notify:

Name: _____ Relationship: _____

Telephone (Home): _____ Cell: _____