Broadway Family Dental Centre
383 East Broadway Vancouver, BC V5T 1W6
604-283-2216

PATIENT INFORMATION

First Name:_____ **Last Name:**_____ **Birthdate(D/M/Y):**_____

Address:_____ **City:**_____ **Postal Code:**_____

Home Phone:_____ **Cell Phone:**_____ **Email:**_____

INSURANCE INFORMATION

Primary Insurance Plan

Holder's Full Name:_____ **Birthdate(D/M/Y):**_____

Name of Insurance Company:_____ **Group/Plan#**_____ **Certificate/ID#**_____

Secondary Insurance Plan

Holder's Full Name:_____ **Birthdate(D/M/Y):**_____

Name of Insurance Company:_____ **Group/Plan#**_____ **Certificate/ID#**_____

MEDICAL / DENTAL HISTORY

Date of last dental visit:_____ **Date of last X-rays:**_____ **Name of previous Dentist:**_____

Have you ever had any reactions to dental freezing? YES ☐ **NO** ☐ **If yes, please explain:**_____

If female, are you pregnant? YES ☐ **NO** ☐ **Possibly:** ☐

Please check if you have ever been treated for:

☐ Heart troubles or Stroke	☐ Thyroid Disease	☐ Cancer
☐ Tuberculosis or Lung Disease	☐ Blood Disorder	☐ Jaundice
☐ Mental or Nervous Disease	☐ Kidney Disease	☐ Asthma
☐ Stomach or Intestinal Ulcers	☐ Diabetes	☐ Epilepsy
☐ Hepatitis or Liver Disease	☐ Injury to Face	☐ A.I.D.S
☐ Rheumatic Fever	☐ High Blood Pressure	☐ Do you grind?
☐ Arthritis or Rheumatism	☐ Growth or Tumor	☐ Do you snore?

Allergies:_____

Prescribed Medication:_____

Is there anything that the Dentist should know regarding your medical status or health that has not been mentioned?

_____

Who may we thank for this referral?_____

This is to certify that I, the undersigned, consent to the performing of the dental and / or oral surgery procedures, agreed necessary or advisable, including oral anaesthetic sedation as indicated, and I will assume responsibility for all fees associated with these procedures.

Patient/Parent signature:_____ **Date:**_____