kits-endo.ca

KITSILANO endo

Certified Specialists in Endodontics

Dr. Pommy Hallen, Dr. Simon Abbey and Dr. Anthony Mo

402-2150 West Broadway
Vancouver, BC V6K 4L9
Phone: 604-731-3377 Fax: 604-731-3007

Patients Registration Form

Patient Name	(Family)	(Given)		*Medical Alert _____
Female ☐	Male ☐		Date of Birth	
Address				
City			Province	Postal Code
Home Phone			Mobile Phone	
Email			Work Phone	
Occupation				
Employer				
Business Address				
City			Province	Postal Code
Emergency Contact			Phone	
Family Doctor			Phone	
Referring Dentist				
Is a Minor	☐ Yes ☐ No		Legal Responsibility	

Primary Plan			
Insurance Carrier			
Group/Policy No.		ID/Certificate	Division
Subscriber			Date of Birth (Year/Month/Day)
Employer			
Secondary Plan			
Insurance Carrier			
Group/Policy No.		ID/Certificate	Division
Subscriber			Date of Birth (Year/Month/Day)
Employer			

I understand that the total payment for the dental services is my responsibility and is **NOT** that of the insurance company. Our office will be pleased to complete any insurance forms and electronically submit them whenever possible so that you may be **REIMBURSED** by your insurance for the percentage of your insurance company's fee guide under your policy.

X _____

(Patient/Parent/Guardian's Signature

MEDICAL HISTORY ON PAGE TWO

1. Are you feeling pain or discomfort at this time? ☐ Yes ☐ No
2. Have you had a medical examination in the last year? ☐ Yes ☐ No
3. Do you feel very anxious about having dental treatment? ☐ Yes ☐ No
4. Have you been a patient in the hospital during the past two years? ☐ Yes ☐ No
5. Please list all medications you are on now:

6. Are you allergic or have you reacted to any of the following medications? Please check which ones:

☐ Aspirin	☐ Erythromycin	☐ Novocaine	☐ Sleeping Pills
☐ Codeine	☐ Local Anesthetic	☐ Penicillin	☐ Tetracycline
☐ Darvon	☐ Nembutal/Seconal	☐ Percodan	☐ Valium
☐ Demerol	☐ Nitrous Oxide	☐ Scopolamine	☐ Other Antibiotics

7. Are you aware of being allergic to any other medications or substance? If yes, please specify ☐ Yes ☐ No

8. Check all of the following which you have/had:

☐ AIDS	☐ Cortisone	☐ Heart Surgery	☐ Heart Pacemaker
☐ Allergies/Hive	☐ Cough	☐ Hemophilia	☐ Scarlet Fever
☐ Angina Pectoris	☐ Diabetes	☐ Hepatitis A (Infectious)	☐ Sickle Cell Disorder
☐ Anemia	☐ Drug Addiction	☐ Hepatitis B (Serum)	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Emphysema	☐ Herpes	☐ Stomach Problems
☐ Artificial Joint(s)	☐ Epilepsy/Seizures	☐ High Blood Pressure	☐ Thyroid Disease
☐ Arthritis	☐ Fainting/Dizzy Spells	☐ HIV Positive	☐ Tuberculosis (TB)
☐ Asthma	☐ Fever Blisters	☐ Kidney Trouble	☐ Ulcers
☐ Blood Transfusion	☐ Glaucoma	☐ Liver Disease	☐ Venereal Disease
☐ Bruise Easily	☐ Hay Fever	☐ Lung Disease	☐ X-Ray/Cobalt Treatment
☐ Cancer	☐ Heart Disease	☐ Pain in Jaw Joints	☐ Yellow Jaundice
☐ Cold Sores	☐ Heart Failure	☐ Rheumatism	
☐ Congenital Heart Lesions	☐ Heart Murmur		

9. When walking upstairs or taking a walk, do you ever stop because of pain in your chest? ☐ Yes ☐ No
10. Do you ever wake up from sleep short of breath? ☐ Yes ☐ No
11. Do you have a tendency to faint? ☐ Yes ☐ No
12. Do you have frequent severe headaches? ☐ Yes ☐ No
13. Have you had regular dental examinations (annually) in the past? ☐ Yes ☐ No
14. If you have any disease, condition, or problem not mentioned above please list:

15. Are you pregnant? (Female Patients Only): ☐ Yes ☐ No

I, the undersigned, being the patient, parent or guardian of the above minor patient, hereby authorize the Doctor, upon consultation and direct consent from the patient to take x-rays, photographs, or any other diagnostic aid deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform and administer any and all forms of treatment, medication, anesthetic and therapy, as may be deemed advisable by the Doctor further to the consultation and direct consent I also understand that upon completion of root canal therapy in this office I will be referred to my dentist for a permanent restoration such as an amalgam, onlay or crown.

X _____ _____

(Patient/Parent/Guardian's Signature **Date Signed**