North Delta Dental Professionals

General Dentistry & Orthodontics

Dr. Glenn G. Chu Inc. #105-8035 120th Street, Delta, B.C. V4C 6P8 www.dentistinnorthdelta.com 604-594-7544

PATIENT INFORMATION (Please Print) DATE _____ AGE _____

☐ MR. ☐ MRS. ☐ MS. ☐ MISS. _____ ☐ M ☐ F BIRTHDATE

LAST FIRST CALLED BY MIDDLE DAY MONTH YEAR

HOME ADDRESS _____ HOME PHONE _____

CITY/PROV. _____ POSTAL CODE _____

EMPLOYER _____ BUS. PHONE _____

PHYSICIAN _____ CEL PHONE _____

IDENTIFICATION: Drivers Lic. No. _____ (Present to Receptionist) Email _____

Credit Card No. _____ Expiry _____

SPOUSE/COMMON LAW INFORMATION (if applicable)

NAME _____

EMPLOYER _____ BUS. PHONE _____

IF PATIENT A MINOR

FATHER'S NAME _____ EMPLOYER _____ BUS. PHONE _____ BIRTHDATE _____

MOTHER'S NAME _____ EMPLOYER _____ BUS. PHONE _____ BIRTHDATE _____

PATIENT CONSENT I Hereby authorize necessary dental services for: _____ Signature X _____

*Whom may we thank for referring you to our office?

_____

FINANCIAL POLICY

* I acknowledge full responsibility for the payment of all dental services and agree to pay for them **in full at the time of service.**

Signature: X _____ **Date:** _____

DENTAL INSURANCE INFORMATION - Present Card to Receptionist

1) (A) BASIC _____% (B) CROWN & BRIDGE _____% (C) DENTURES _____% (D) ORTHO _____% AGE LIMIT _____

(A) LIMIT _____ (B) LIMIT _____ (C) LIMIT _____ (D) LIMIT _____ DEDUCTIBLE _____

INSURANCE COMPANY NAME _____ POLICY/GROUP NO. _____

CERTIFICATE NO. _____ DIV NO. _____ R/C LIMIT _____ SC/RP LIMIT _____

NAME OF POLICY HOLDER _____ BIRTHDATE _____ DAY MONTH YEAR

1) (A) BASIC _____% (B) CROWN & BRIDGE _____% (C) DENTURES _____% (D) ORTHO _____% AGE LIMIT _____

(A) LIMIT _____ (B) LIMIT _____ (C) LIMIT _____ (D) LIMIT _____ DEDUCTIBLE _____

INSURANCE COMPANY NAME _____ POLICY/GROUP NO. _____

CERTIFICATE NO. _____ DIV NO. _____ R/C LIMIT _____ SC/RP LIMIT _____

NAME OF POLICY HOLDER _____ BIRTHDATE _____ DAY MONTH YEAR

MEDICAL HISTORY

All information is strictly confidential. Although some questions may seem unimportant at this moment, they are essential for dental care and vital in emergencies.

1. Name of physician _____ Telephone _____
   (a) Are you currently being treated for any conditions? YES ☐ NO ☐

   _____

2. Are you taking any drugs or medication? YES ☐ NO ☐
   (a) If so, please list:

   _____

3. Please circle any of the following that you have:

AIDS or HIV positive	Endocrine disorder eg. thyroid disease	Lung or breathing disorders
Asthma	Fainting spells or seizures (epilepsy)	Muscle or joint disorder
Blood or clotting disorder	Gastrointestinal disease, eg. ulcers	Rheumatic fever
Bone disorder / osteoporosis	Heart attack, heart trouble	Sleep Apnea, Snoring
Cancer	Heart murmur	Stroke
Chest pains or shortness of breath	Hepatitis, jaundice or liver disease	TMJ (jaw joint) pain
Congenital heart lesions	High blood pressure	Venereal disease
Diabetes - diet or insulin controlled	Kidney disease	

4. Drug allergies or reactions - please list:

   _____

5. Have you ever had abnormal bleeding associated with previous extraction, surgery or trauma? YES ☐ NO ☐

6. Women - Are you pregnant or might be pregnant? YES ☐ NO ☐

7. Do you have any disease or medical problem not listed above?
   (a) If so, please explain:

   _____

8. What dental conditions concern you at present?

   _____

9. Date of last visit? _____ Previous Dentist _____

10. Are you nervous about receiving dental treatment? YES ☐ NO ☐

11. What is the most important concern to you regarding dental work? Please circle the applicable:

    Cost / Time / Appearance / Discomfort

12. Are you happy with the appearance of your teeth? YES ☐ FAIRLY ☐ NO ☐

13. Are you interested in DR. CHU DOING BRACES / COSMETIC WORK? YES ☐ NO ☐

14. ARE YOU AVAILABLE ON SHORT NOTICE? YES ☐ NO ☐