

NW Endodontics

Dr. Eric C.K. Law

PATIENT INFORMATION

Name	Last	First	Preferred
	Male / Female		
Address	Street		
	City	Prov	Postal Code
Birthdate	DD	MM	YYYY
Telephone	Cell	Home	Work
Email Address			
Alberta Health Care #			
Emergency Contact	Name:	Phone:	

INSURANCE INFORMATION

	<input type="radio"/> Yes	<input type="radio"/> No
Primary Dental Insurance	Secondary Dental Insurance	
Insurance Company	Insurance Company	
Name of Subscriber	Name of Subscriber	
Date of Birth	Date of Birth	
	DD/MM/YY	DD/MM/YY
Group or Plan #	Group or Plan #	
Identification #	Identification #	
Name of Employer	Name of Employer	

PAYMENT

As the patient (or legal guardian) you are responsible for full payment of any services received on the day of service regardless of insurance coverage. We DO NOT accept payment from insurance companies. Full payment must be made to our office by the patient or guardian. Any insurance reimbursement will go directly to the plan holder.

ELECTRONIC INSURANCE CLAIM SUBMISSION CONSENT

I authorize the release of information to my dental benefits plan administrator and the Canadian Dental association information contained in claims submitted (electronically). I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

Patient / Legal Guardian Signature

DD/MM/YYYY

MEDICAL HISTORY

Family Physician _____ Phone _____

Are you currently under the care of a physician? Yes No

if yes, please explain: _____

Have you been hospitalized for major surgery? Yes No

If yes, please describe: _____

Do you have any health problems that require further clarification? Yes No

if yes, please explain: _____

Have you ever had any complications following dental treatment? Yes No

If yes, please describe: _____

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? Check YES OR NO

Anemia	<input type="radio"/> Yes <input type="radio"/> No	Joint Replacement (hip, knee, etc.)	<input type="radio"/> Yes <input type="radio"/> No
Arthritis / Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve / Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Pressure: HIGH or LOW	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No
Blood Disorder	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Neurologic Problems	<input type="radio"/> Yes <input type="radio"/> No
Diabetes: TYPE 1 or TYPE 2	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Radiation / Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No
Epilepsy / Seizures	<input type="radio"/> Yes <input type="radio"/> No	Respiratory Problems	<input type="radio"/> Yes <input type="radio"/> No
Gag Reflex	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
GI troubles / IBS / Colitis	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Condition	<input type="radio"/> Yes <input type="radio"/> No
Head Injuries	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Heart Condition	<input type="radio"/> Yes <input type="radio"/> No	Tumors	<input type="radio"/> Yes <input type="radio"/> No
Hepatitis: A B C	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
HIV / AIDS	<input type="radio"/> Yes <input type="radio"/> No		

Please list any other serious medical conditions you have or had in the past:

Please list any current medication(s) you are taking:

Do you have a medical condition that requires a Pre-Medication prior to dental treatment? Yes No

Please List Known Allergies To Any Of The Following:

Penicillin	<input type="radio"/> Yes <input type="radio"/> No	Tetracycline	<input type="radio"/> Yes <input type="radio"/> No
Sedatives	<input type="radio"/> Yes <input type="radio"/> No	Codeine	<input type="radio"/> Yes <input type="radio"/> No
Erythromycin	<input type="radio"/> Yes <input type="radio"/> No	Keflex	<input type="radio"/> Yes <input type="radio"/> No
Sulfa Drugs	<input type="radio"/> Yes <input type="radio"/> No	Aspirin	<input type="radio"/> Yes <input type="radio"/> No
Metals	<input type="radio"/> Yes <input type="radio"/> No	Local Anesthetic	<input type="radio"/> Yes <input type="radio"/> No
Latex	<input type="radio"/> Yes <input type="radio"/> No	Ibuprofen	<input type="radio"/> Yes <input type="radio"/> No

ADDITIONAL KNOWN ALLERGIES:

For Women:

Are you taking any Birth Control Medication? Yes No

Are you Pregnant? Yes No

Are you Nursing? Yes No

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