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 Home Work Cell

Email Address

Alberta Health Care #

Emergency Contact Name: Phone:

INSURANCE INFORMATION

◯ **Yes** ◯ **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 #	
Idenification #		Identification #	
Name of Employer		Name of Employer	

PAYMENT INFORMATION

We accept the following payment: Debit card, Visa, Mastercard or Cash
Payment for services is due the day of the appointment
I understand that I am fully responsible for prompt payment of my account

Patient / Legal Guardian Signature DD/MM/YY

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 (electonically). I also authorize the communication of information related to the coverage of servies described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

Patient / Legal Guardian Signature DD/MM/YY

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

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

_____

Please list any current medication 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	◯ **Yes** ◯ **No**	Tetracycline	◯ **Yes** ◯ **No**
Sedatives	◯ **Yes** ◯ **No**	Codeine	◯ **Yes** ◯ **No**
Erythromycin	◯ **Yes** ◯ **No**	Keflex	◯ **Yes** ◯ **No**
Sulfa Drugs	◯ **Yes** ◯ **No**	Aspirin	◯ **Yes** ◯ **No**
Metals	◯ **Yes** ◯ **No**	Local Anesthetic	◯ **Yes** ◯ **No**
Latex	◯ **Yes** ◯ **No**	Ibuprofen	◯ **Yes** ◯ **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**