KENSINGTON SQUARE DENTAL CENTRE

Welcome to Our Office

604-298-5595

Dr. Ivan Jin, Dr. Grace Wong & Associates

Today's Date: _____ **Date of Birth: _____**

Name: Last: First: Middle Initial:

Address: _____City: _____ Postal Code: _____

Telephone No.: **Home: _____ Work: _____ Cell: _____**

Email address: _____

Please specify preferred contact method: _____

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT:

Name: _____ Phone #: _____ Relation: _____

Who may we thank for referring you?

Walk by	Internet	Patient? (if so name) fdfd	Other

DENTAL INSURANCE INFORMATION

Primary Insurance Co:		**Secondary Insurance Co:**	
Name of Insured:		**Name of Insured:**	
Date of Birth:		**Date of Birth:**	
Employer:		**Employer:**	
I.D/Certificate Number:		**I.D/Certificate Number:**	
Group Number:		**Group Number:**	
Basic %	**Major %**	**Basic %**	**Major %**
Ortho %	**Deductible?**	**Ortho %**	**Deductible?**
Yearly Maximum?		**Yearly Maximum?**	

HEALTH QUESTIONNAIRE

1. Have you been examined/treated by a physician this year? YES/NO
2. Physician's Name + Phone No. _____
3. Have you ever experienced abnormal bleeding after surgery or trauma? YES/NO
4. Women: Are you pregnant? **YES** **NO** **OR** Taking birth control? YES/NO
5. Have you ever been seriously ill or hospitalized? YES/NO
6. Have you had any major operations? YES/NO
7. Have you ever been involved in a serious accident? YES/NO

Click to place a checkmark beside any of the following that you have had unusual or allergic reactions to:

ASPIRIN	CODEINE	ANESTHETIC	PENICILLIN	LATEX

Do you have any medical conditions we should be aware of?	
Are you taking any medications or non-prescription drugs at this time?	

Click to place a checkmark beside any of the following you have been diagnosed with and/or treated for:

ANEMIA	GLAUCOMA	KIDNEY DISEASE
ASTHMA	HAY FEVER	RHEUMATIC FEVER
DIABETES	HEART MURMUR	SINUS TROUBLE
EMPHYSEMA	HEPATITS A B C	STROKE
EPILEPSY	JAUNDICE	TUBERCULOSIS
STOMACH ULCERS	VENEREAL DISEASE	HIV/AIDS
HIGH/LOW BLOOD PRESSURE	DIZZINESS/FAINTING	CANCER
BRUISING/BLEEDING PROBLEI	OTHER:	

DENTAL HISTORY

Date of last dental visit: _____ Former Dentist: _____

Do you use tobacco? How much/how often? _____ YES/NO

Have you had regular dental care (annually) in the past? YES/NO

How often do you brush/floss your teeth? _____

Do you have any oral habits such as clenching, grinding or nail biting? YES/NO

Are you happy with the function and appearance of your teeth? YES/NO

If no, what would you like to change? _____

What dental condition, if any, concerns you right now? _____

OUR OFFICE POLICY

Please read the following carefully:

Your appointment time will be reserved especially for you. If you are unable to keep your appointment **we will require 48 hours' notice** (two full business days) otherwise, a charge will be incurred.

Please inform us of your dental insurance coverage. **It is the patient's responsibility to know what is covered under their plan. Your contract is between you and your insurance company; we cannot keep track of coverage and/or limits.**

My signature below indicates that I have been informed of the office policies; I consent to treatment, and assume all responsibility for payment of fees which are not covered by my dental plan.

Signature: _____

Date signed: _____

Please print name: _____