KELOWNA ORAL & FACIAL SURGERY
KELOWNAORALSURGERY.COM

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V1Y 0G1

PATIENT INFORMATION:

Today's Date_____

Legal Name _____ Preferred Name (if different) _____

Sex: ○ M ○ F (Insurance Purposes Only) Pronouns (Optional): _____ Birth Date _____ (DD/MM/YYYY) E-mail _____

Address _____ Apt. _____ City _____ Province _____ Postal Code _____

Best Contact Tel. (_____) _____ Other Contact Tel. (_____) _____

Have you ever been a patient of our practice? ○ Yes ○ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME)

Medical Dr. _____ (FIRST NAME) _____ (LAST NAME) Preferred Pharmacy _____ Tel.(_____) _____

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

○ Self (If self, skip this section) ○ Spouse ○ Father ○ Mother ○ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) E-mail _____

Best Contact Tel. (_____) _____ Other Contact Tel. (_____) _____

PRIMARY DENTAL INSURANCE COMPANY:

Ins. Co. Name _____

I.D. # / Cert. # _____

Group # / Contract _____

Policy Holder _____ (FIRST NAME) _____ (LAST NAME)

Policy Holder's Birth Date _____ (MM/DD/YYYY)

SECONDARY DENTAL INSURANCE COMPANY:

Ins. Co. Name _____

I.D. # / Cert. # _____

Group # / Contract _____

Policy Holder _____ (FIRST NAME) _____ (LAST NAME)

Policy Holder's Birth Date _____ (MM/DD/YYYY)

CANADIAN MEDICAL INSURANCE:

Province _____ Health Care # _____

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit?

		Yes	No
1.	***Height*** _____ ***Weight*** _____ Are you in good health?	○	○
2.	Have there been any changes in your general health in the past year?	○	○
3.	Are you under the care of a physician for a specific medial condition?	○	○
4.	Have you had any illness, operation or been hospitalized in the past five years?	○	○
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	○	○
6.	Do you have a prosthetic joint / implant?	○	○
7.	Have you had a heart valve replacement or vascular graft?	○	○
8.	Have you ever had general anesthesia?	○	○
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	○	○
	If so, what was the reaction? _____		
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	○	○

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?	○	○	
12. Damaged heart valves / artificial valves?	○	○	
13. Heart murmur?	○	○	
14. High blood pressure?	○	○	
15. Low blood pressure?	○	○	
16. Chest pain / angina?	○	○	
17. Heart attack(s)?	○	○	
18. Irregular heart beat?	○	○	
19. Cardiac pacemaker?	○	○	
20. Heart surgery?	○	○	
21. Chronic respiratory / lung conditions?	○	○	
22. Asthma?	○	○	
23. Sleep apnea / CPAP / snoring?	○	○	
24. Do you smoke?	○	○	
25. Do you vape?	○	○	
26. Do you use marijuana / cannabis?	○	○	
27. Do you use recreational drugs?	○	○	
28. Do you use chewing tobacco?	○	○	
29. Blood disorder such as anemia / leukemia?	○	○	
30. Bruise easily?	○	○	
31. Bleeding tendency / abnormal bleed?	○	○	
32. Fainting spells?	○	○	
33. Convulsions / epilepsy?	○	○	
34. Stroke?	○	○	
35. Thyroid trouble?	○	○	

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
36. Diabetes?	○	○	
37. If yes: on insulin?	○	○	
38. Low blood sugar?	○	○	
39. Kidney trouble?	○	○	
40. Are you on dialysis?	○	○	
41. High cholesterol?	○	○	
42. Arthritis / joint disease?	○	○	
43. Osteoporosis / osteopenia?	○	○	
44. Gastrointestinal issues (acid reflux, ulcers, inflamatory bowel disease)?	○	○	
45. Contagious diseases? If yes, please list:	○	○	
46. Problems with immune system? Possibly from medication / surgery, etc.	○	○	
47. Delay in healing?	○	○	
48. A tumor or growth?	○	○	
49. Cancer / radiation therapy / chemotherapy?	○	○	
50. Chronic fatigue / night sweats?	○	○	
51. Are you on a diet?	○	○	
52. A history of alcohol abuse?	○	○	
53. Contact lenses?	○	○	
54. Eye disease / glaucoma?	○	○	
55. Mental health problems / anxiety / depression?	○	○	
56. Behavioural / cognitive / developmental disorder?	○	○	

57. Is there a family history of:
☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Anesthesia problems

WOMEN ONLY:

	Yes	No
58. Have you been advised to avoid NSAIDs?	○	○
59. Is there a possibility of pregnancy?	○	○
60. Expected delivery date? _____		
61. Are you nursing?	○	○

PLEASE ELABORATE ON YOUR HEALTH HISTORY IF APPLICABLE:

ARE YOU NOW TAKING:	YES	NO	NOTES
62. Blood thinners?	○	○	
63. Any herbal supplements or homeopathic remedies?	○	○	
64. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphos-phonates in the past 12 years?	○	○	

65. Have you ever taken tranquilizers, sleeping pills, anti-depressants and/or narcotics on a regular basis. If yes, please list:

66. If you are under the care of a physician for pain management, or recovering from drug addiction please select the medication you are currently taking: ☐ Methadone ☐ Suboxone ☐ Oxycodone ☐ Fentanyl ☐ Other _____
Treating doctor: _____

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
67. Local anesthetic (freezing)?	○	○	
68. Penicillin / amoxicillin?	○	○	
69. Sulfa drugs?	○	○	
70. Clindamycin?	○	○	
71. Aspirin / ibuprofen?	○	○	
72. Other antibiotics?	○	○	
73. Codeine or other narcotics?	○	○	
74. Latex?	○	○	

75. Please list any other allergies:

76. Are you taking any medications?	Yes	No
	○	○

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Medication	Dosage	Frequency

ACCIDENT HISTORY:

Is this visit related to an accident? ○ Yes ○ No

If Yes, what type of accident? ○ Automobile ○ Work related ○ Other

Date of injury ______________________________

Insurance company handling the claim ______________________________

Claim number ______________________________

Name of attorney / adjustor ______________________________

Telephone number (______) ______________________________

VERIFICATION

I certify that I have read and I understood the questions above. I affirm and certify that all the information and answers to questions herein are complete, true and correct to the best of my knowledge and belief. I will not hold my doctor, or any member of the staff at Kelowna Oral & Facial Surgery, responsible for any errors or omissions that I have made in the completion of this form.

If I have chosen to have sedation or general anesthesia as part of my surgery today, I certify that I have not had anything to eat or drink in the past 8 (eight) hours.

FEES & PAYMENTS

Payment is due in full at the time treatment is rendered. An estimate of the costs for any procedure or surgery you may require will be provided to you. If you have dental insurance we will be glad to fill out the claim forms on your behalf, and you will be reimbursed directly according to your insurance plan.

This signature on file is my authorization for the release of information necessary to process my claim.

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile device concerning my care.

PHARMANET CONSENT

I authorize my surgeon and his/her designated nursing staff to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me. Pharmanet is the provincial pharmacy network and database. I understand that withdrawal of this consent must be delivered in writing.

X ______________________________ **X** ______________

Signature of patient *(Parent or Guardian if Minor)* **Date**