RADIANCE DENTAL CENTRE
WE MAKE YOUR SMILE SHINE

Dr. Ewa Lesinska Kostamo Inc. & Associates
Dentist, UBC DMD

215 Lonsdale Ave. North Vancouver, B.C. T: 604-988-1231 F: 604-988-1263

(the following confidential information is for our records only)

Name:
Mr., Mrs., Ms., Dr. _____
Last Name First Middle Initial(s)

Date of Birth: D ___ / M ___ / Y ___

Home Address: _____
Street City Postal Code

Email Address: _____

Home#( )___-_____ Business #( )___-_____ Cell # ( )___-_____

Name of spouse, parent or nearest relative: _____ Phone # ( ) ___-_____

If patient is a minor, who is legally responsible: _____

Employer _____ Occupation _____

Family Physician _____ Office # ( ) ___-_____

Insurance Information (if applicable):

Primary Insurance: _____

Group/Policy #_____

ID/Cert # _____

Dep #_____

Employer_____

If primary coverage through spouse/partner, then please fill in:

Their name _____

Date of Birth: D____ /M____ /Y_____

Secondary Insurance:_____

Group/Policy # _____

ID/Cert # _____

Dep #_____

Spouse/Partner's Name _____

Date of Birth: D____ /M____ /Y_____

Employer name: _____

Phone # ( ) _____-_____

Occupation: _____

Dual Insurance Coverage for minors - requires both parent's birthdates:

Mother's Date of Birth: D____ /M____ /Y_____ Father's Date of Birth: D ____/M ____/Y _____

I authorize the release of any information relating to dental claims.

I understand that I am responsible for all the costs of dental treatment.

** We will submit the primary insurance claim and prepare any secondary claim forms on your behalf*

Upon being informed of the treatment options, I the undersigned, being the patient or if a minor, the parent or guardian, consent to diagnostic procedures, x-rays and treatments determined necessary by the Dentist. I authorize and request the administration of such drugs and/or local anaesthetics, as may be deemed advisable by the Dentist. I have been informed that the use of local anaesthetic carries with it the risks of pain, swelling, bruising, hematoma, infection, muscle spasm, allergic reaction, racing of the heart, increase in blood pressure, dizziness, drowsiness, nerve damage and temporary or permanent numbness.

We require 48 hours notice if you need to cancel an appointment, or a $60 fee will be applied to your account.

Patient/Parent/Guardian signature:_____ Date: D____ /M____ /Y_____

Reviewed by: _____

Medical History

Please answer the following questions. Your answers are for our records only, and considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Your Care Card #_____/_____/_____

Yes. No.

- ❑ ❑ 1. Are you currently under the care of a physician?
- ❑ ❑ 2. What are you currently being treated for? _____
- ❑ ❑ 3. Have you had any serious illness, operation, or been hospitalized in the past 5 years
- ❑ ❑ 4. If so, what was the illness/reason?_____
- ❑ ❑ 5. Are you currently taking any medication? (prescribed or not)
- ❑ ❑ 6. If so, what are you taking?_____

Does your medical history include any of the following?

Yes. No.

- ❑ ❑ 7. Rheumatic or congenital (inborn) heart disease?
- ❑ ❑ 8. Heart murmur, damage, or artificial heart valves? If yes, do you require pre-medication? Yes ❑ No ❑
- ❑ ❑ 9. Cardiovascular disease (heart trouble, stroke)?
- ❑ ❑ 10. High or low blood pressure If yes, do you take medication? Yes ❑ No ❑
- ❑ ❑ 11. Do you have a cardiac pacemaker?
- ❑ ❑ 12. Asthma, emphysema, or tuberculosis?
- ❑ ❑ 13. Fainting, seizures, epilepsy, or neurological disorders?
- ❑ ❑ 14. Diabetes? If yes, do you take medication? Yes ❑ No ❑
- ❑ ❑ 15. Hepatitis, jaundice, or other liver disease?
- ❑ ❑ 16. Sexually transmitted disease?
- ❑ ❑ 17. Aids or HIV Infection?
- ❑ ❑ 18. Thyroid problems? If yes, do you take medication? Yes ❑ No ❑
- ❑ ❑ 19. Stomach ulcer?
- ❑ ❑ 20. Kidney Trouble?
- ❑ ❑ 21. Problems with mental health?
- ❑ ❑ 22. Cancer or treatment for tumor or growth?
- ❑ ❑ 23. Radiation therapy for Cancer? area of body treated: _____ date: _____/_____/_____
- ❑ ❑ 24. Problems of the Immune system?
- ❑ ❑ 25. Blood disorders, such as anemia?
- ❑ ❑ 26. Abnormal bleeding?
- ❑ ❑ 27. Have you had joint replacement surgery (knee, hip, etc?) Do you require pre-medication? Yes ❑ No ❑
- ❑ ❑ 28. Do you have any other illness or conditions not mentioned above?

Are you allergic or had any reaction to:

Yes. No.

- ❑ ❑ 29. Penicillin or other antibiotics?
- ❑ ❑ 30. Sulfa Drugs?
- ❑ ❑ 31. Aspirin, Acetaminophen (Tylenol), or Ibuprofen (Advil, Motrin)?
- ❑ ❑ 32. Codeine or other narcotics?
- ❑ ❑ 33. Barbiturates, sedatives, or sleeping pills?
- ❑ ❑ 34. Local anesthetic?
- ❑ ❑ 35. Any other drugs or medications?

For women patients:

Yes. No.

- ❑ ❑ 36. Are you pregnant?
- ❑ ❑ 37. Are you nursing?

In regards to your own health and our staff's health, please sign below to certify that you have answered each question to the best of your knowledge.

Signature_____ Date:____/___/_____

PATIENT DENTAL HISTORY

Patient's name _____ Date of Birth _____

Reason for this visit _____

Last dental visit (date)_____ Treatment provided at that time _____

Frequency of dental visits_____ Previous dentist (name and location)_____

Have you had a complete series of dental films/x-rays taken?_____ Where? _____

When? _____ Can we request these be sent to our office? _____

Please indicate Yes (Y) or No (N) to the following:

Do your gums bleed while brushing or flossing? _____

Are your teeth sensitive to hot or cold? _____

Are your teeth sensitive to sweet or sour? _____

Do you feel pain in any of your teeth? _____

Do you have any sores or lumps in or near your mouth? _____

Have you ever had any head, neck or jaw injuries? _____

Have you ever experienced any of the following problems in your jaw?

- Clicking _____
- Pain (joint, ear or side of face) _____
- Difficulty in opening/closing _____
- Difficulty in chewing _____

Do you have frequent headaches? _____

Do you clench or grind your teeth? _____

Do you bite your lips/cheeks frequently? _____

Have you noticed any loosening of your teeth? _____

Does food get caught between your teeth? _____

Have you had periodontal (gum) treatment? _____

Have you received oral hygiene instructions for the care of your teeth and gums? _____

Have you had difficult extractions before? _____

Have you had prolonged bleeding following extractions before? _____

Do you wear dentures or partials? _____

If yes, date of placement _____

Do you have dental implants? _____

If yes, date of placement _____

Have you had orthodontic treatment? _____

If yes, date of placement _____

Have you had treatment from a dental specialist?_____

If yes, what type?_____

Additional comments or concerns? _____

_____

_____

Dentist's comments _____

_____

_____

_____ _____ _____ _____

Patient's/Parent's/Guardian's signature Date Dentist's signature Date