Email: info@citycentreendodontics.com Phone: 604-669-2364
Web: www.vancouverendo.ca Fax: 604-669-5710

Name:

Birthdate (mm/dd/yy): Male: Female:

Address:

City: Postal Code:

Phone #s: Home# Cell# Work#

Email:

Occupation: Employer:

Referred by: Physician:

Insurance Provider:

MEDICAL HISTORY	YES	NO
Are you in good health?		
Have you ever had excessive bleeding requiring special treatment?		
Are you allergic or sensitive to novocaine, penicillin, codeine, sulphur or any other medications?		
Have you ever had an unfavourable reaction following dental treatment?		
Are you HIV positive?		
Female Patients: Are you currently pregnant?		

Please list medications you are currently taking:

HAVE EVER HAD THE FOLLOWING:

Heart Condition	Asthma	Diabetes	Liver/ Blood Condition
Epilepsy/Seizures	Respiratory Conditions	Rheumatic Fever	Kidney Condition
Drug History	High/Low Blood Pressure	Ulcers/ Colitis	Hepatitis

Date: Signature:

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OFFICE FINANCIAL POLICY (Please read before signing)

If we ONLY provide Endodontic Evaluation/Consultation: This consists of an examination/testing/x-rays, discussing the likelihood of maintaining the tooth and treatment options available to you. Payment is due at the time of service. A standard dental claim form will be provided for reimbursement directly to you from your insurance plan(s).

If we provide Treatment:

1. Treatment will be directly billed to you at the time of service.
2. As a courtesy we will be happy to submit dental claims to your primary insurance provider and provide the required claim forms to allow you submit to your secondary insurance provider.

If you understand and agree with all the above policies, please sign below.

Name:

Date:

Signature:

Spouses Information (if Secondary Insurance):

Spouses Name:

Insurance Provider:

Date of Birth:

Employer: