Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / **PAGE 1 OF 2**

LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB (mm/dd/yy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY \_\_\_\_\_\_\_\_\_\_\_ POSTAL \_\_\_\_\_\_\_\_\_\_\_\_

CARE CARD # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NATIVE STATUS CARD # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER ID# (PAROLE, REFUGEE STATUS#): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU UNDER: INCOME ASSISTANT / EI / DISABILITY / HEALTHY KIDS PROGRAM / WCB / ETC

INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POLICY# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GROUP# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIV# \_\_\_\_\_\_\_\_\_\_ OPTIONAL CODE \_\_\_\_\_ EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL CLINIC LAST SEEN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON OF VISIT TO MEDICAL CLINIC \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONTACT INFO OF YOUR MEDICAL DOCTOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any of the following?

* Acrylic
* Antibiotics
* Aspirin
* Penicillin
* Codeine
* Local anaesthetics
* Metal
* Nitrious Oxide
* Latex
* Dust/pollen
* Sulpha drugs
* Sleeping pills / sedative
* `Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women only: Are you?

* Pregnant Yes € No €
* Trimester? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Taking oral contraceptives Yes € No €
* Nursing Yes € No €

SERIOUS ILLNESS (check more than one if needed)

* AIDS/HIV positive
* Alzheimer’s Disease
* Anaphylaxis
* Anaemia
* Angina
* Arthritis/Gout
* Artificial Heart Valve
* Artificial Joint
* Asthma
* Blood Disease
* Blood thinners
* Breathing Problem
* Bruce Easily
* Cancer
* Cataract Surgery
* Chemotherapy
* Chest Pain
* Circulatory Problems
* Coagulation problems
* Cold Sore/Fever Blisters
* Congenital Heart Disorder
* Convulsions
* COPD
* Depression
* Diabetes
* Drug addiction
* Easily winded
* Emphysema
* Epilepsy or seizures
* Excessive bleeding
* Excessive thirst
* Fainting spells/dizziness
* Frequent cough
* Frequent diarrhea
* Frequent headaches
* Genital herpes
* GI problems
* GI bypass surgery
* Glaucoma
* Hay fever
* Head or Neck Injuries
* Heart attack/failure
* Heart murmur
* Heart pacemaker
* Heart trouble/disease
* Heart valve surgery
* Haemophilia
* Hepatitis A
* Hepatitis B or C
* Herpes
* High Blood Pressure
* High Cholesterol
* Hives or Rash
* Hypoglycaemia
* Irregular heart beat
* Kidney Problems
* Liver Disease
* Low blood pressure
* Lung disease
* Mental/Nervous Disorder
* Medical or Organ Transplant
* Mitral valve prolapsed
* Osteoporosis
* Pain in jaw joints
* Parathyroid disease
* Parkinson
* Psychiatric care
* Radiation treatments
* Recent weight loss
* Renal dialysis
* Rheumatic fever
* Rheumatism
* Scarlet fever
* Shingles
* Sickle cell disease
* Sinus trouble
* Spine bifida
* Stress drugs addictions
* Stroke
* Swelling of limbs
* Thyroid problems
* Tonsillitis
* Tuberculosis (TB)
* Tumour or growths
* Ulcers
* Venereal Disease
* Yellow Jaundice

Have you ever had any serious illness not listed above? Yes € No €

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you taking any current medication? (Including pain killers and antibiotics) Yes € No €

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you advised against taking any type of medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need any prescription prior any dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you know your last BLOOD PRESSURE LEVELS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you taken any BLOOD TEST RECENTLY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you know your last SUGAR LEVEL? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET DURGS/ADDICTIONS last used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you dependant on ALCOHOL OR DURGS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RECOVERY PROGRAM/METHODONE dosage/how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WAIVER – RELEASE CONSENT**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ recognize that my dental care might need immediate treatment and it will require to take into consideration my physical / medical condition. I hereby affirm that I am in a good physical condition and do not suffer from any known disability or condition which would prevent or limit my treatment at the office.

I further understand that I have been advised of alternative treatments for my condition and the specific risks and complications related to it. Therefore, I completely acknowledge; that all my questions have been answered to my satisfaction.

I also acknowledge:

1. That I provided all the information needed to asses my physical health and/or I provided the information needed to contact my Family Doctor.
2. The Dentist/Surgeon is able to administrate the anaesthetics needed for my treatment.
3. That I am under no pressure to sign this consent and I am “*100% under full control of my actions”*, hereby I release the VANCOUVER NATIVE HEALTH SOCIETY – DENTAL CLINIC and its agents from any liability now or in the future for conditions that I may obtain. These conditions may include, but are not limited to: billing submission on my behalf (Ministry, Private Insurance or Native Status), referrals, medical/dental complications related to the treatment received.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**- Dear patient: DON’T FORGET TO SIGN THIS SECTION -**