Vancouver Aboriginal Health Society

PLEASE TAKE THE TIME TO FILL OUT THIS QUESTIONARIE CAREFULLY. THE INFORMATION WILL ASSIST US TO BETTER SERVE YOU, BILL ON YOUR BEHALF &UNDERSTAND YOUR MEDICAL/DENTAL CONDITION VS. YOUR COVERAGE. RECORDS WILL BE KEPT CONFIDENTIAL.

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 _____

REASSON OF VISIT TO MEDICAL CLINIC _____

CONTACT INFO OF YOUR MEDICAL DOCTOR Name:_____Phone#:_____

Are you allergic to any of the following?

- ☐ Acrylic
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Local anaesthetics
- ☐ Metal
- ☐ Nitrous 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)

☐ Alcohol Addiction	☐ COPD	☐ Heart trouble/disease	☐ Pulmonary embolism
☐ AIDS/HIV positive	☐ Depression	☐ Heart valve surgery	☐ Radiation treatments
☐ Alzheimer's Disease	☐ Diabetes (Type 1)	☐ Haemophilia	☐ Recent weight loss
☐ Anaphylaxis	☐ Diabetes (Type 2)	☐ Hepatitis A	☐ Renal dialysis
☐ Anaemia	☐ Drug addiction	☐ Hepatitis B or C	☐ Rheumatic fever
☐ Angina	☐ Easily winded	☐ Herpes	☐ Rheumatism
☐ Arthritis/Gout	☐ Emphysema	☐ High Blood Pressure	☐ Scarlet fever
☐ Artificial Heart Valve	☐ Epilepsy or seizures	☐ High Cholesterol	☐ Shingles
☐ Artificial Joint	☐ Excessive bleeding	☐ Hives or Rash	☐ Sickle cell disease
☐ Asthma	☐ Excessive thirst	☐ Hypoglycaemia	☐ Sinus trouble
☐ Blood Disease	☐ Fainting spells/dizziness	☐ Irregular heartbeat	☐ Spine bifida
☐ Blood thinners	☐ Frequent cough	☐ Kidney Problems	☐ Stress drugs addictions
☐ Breathing Problem	☐ Frequent diarrhoea	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Frequent headaches	☐ Low blood pressure	☐ Swelling of limbs
☐ Cancer (area_____)	☐ Genital herpes	☐ Lung disease	☐ Thyroid problems
☐ Cataract Surgery	☐ GI problems	☐ Mental/Nervous Disorder	☐ Tonsillitis
☐ Chemotherapy	☐ GI bypass surgery	☐ Medical or Organ Transplant	☐ Tuberculosis (TB)
☐ Chest Pain	☐ Glaucoma	☐ Mitral valve prolapsed	☐ Tumour or growths
☐ Circulatory Problems	☐ Hay fever	☐ Osteoporosis	☐ Ulcers
☐ Coagulation problems	☐ Head or Neck Injuries	☐ Pain in jaw joints	☐ Venereal Disease
☐ Cold Sore/Fever Blisters	☐ Heart attack/failure	☐ Parathyroid disease	☐ Yellow Jaundice
☐ Congenital Heart Disorder	☐ Heart murmur	☐ Parkinson	
☐ Convulsions	☐ Heart pacemaker	☐ Psychiatric care	

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

_____

_____

Any recent surgeries or medical procedures: _____

_____

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Are you taking any current medication? (Including pain killers and antibiotics) Yes ☐ No ☐
Please provide a list from your pharmacy (if available)

_____

_____

Pharmacy you attend_____

Dental fears on a scale of 1 to 10 please rate your fear! _____

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 (A1C) _____

STREET DRUGS/ADDICTIONS last used _____

Are you dependant on ALCOHOL OR DRUGS? _____

RECOVERY PROGRAM/METHODONE dosage/how long _____

WAIVER – RELEASE CONSENT

I __print your name_____ 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 assess 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. I give my implied consent for all Xrays, CTScans and or Pan Xrays, or any other medium to be taken to aid in my overall treatment.
4. 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: _____

- DONT FORGET TO SIGN THIS SECTION -