Dr. Stephanie Tsang
FAMILY DENTISTRY

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T (604) 852 2419
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Welcome to our practice! In an effort to serve you better, we would ask that you complete the following:

Personal Information

Title ______ Name ____
First Last

Gender Male ☐ Female ☐

Birthdate ___/___/___ (mm/dd/yy)

Home Phone ______________________________

Work Phone ______________________________

Cell Phone ______________________________

Occupation ______________________________

Employer ______________________________

Emergency Contact ______________________

Relationship ______________________

Phone Number ______________________

Address ______________________________

City ______________________________

Postal Code ______________________________

Email ______________________________

May we contact you via email? Yes ☐ No ☐

Preferred method of contact
Email ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐

Whom may we thank for referring you to our office?
____

Insurance Information

Primary Insurance ______________________

Policy Number ______________________
Subscriber ID ______________________
Subscriber's Name ______________________
Subscriber's DOB ___/___/___ (mm/dd/yy)
Relationship to Subscriber ______________

Secondary Insurance ______________________

Policy Number ______________________
Subscriber ID ______________________
Subscriber's Name ______________________
Subscriber's DOB ___/___/___ (mm/dd/yy)
Relationship to Subscriber ______________

Dental History

Previous Dentist ______________________

Date of Last Visit ______________________

Date of Last X-rays ______________________

Are you nervous or concerned about having dental work done? Yes ☐ No ☐

Have you ever had a reaction to local anesthetic? Yes ☐ No ☐

Have you had orthodontic treatment (braces) in the past? Yes ☐ No ☐

Have you had TMJ (jaw joint) problems in the past? Yes ☐ No ☐

Are you happy with the appearance of your teeth? Yes ☐ No ☐

Medical History

Physician ______________________________

Date of Last Visit ________________________

Are you allergic to any medication, latex, or other substance? Yes ☐ No ☐
If yes, please list
____

Have you ever been required to take to take premedication before a dental appointment?
Yes ☐ No ☐

Have you been treated for osteoporosis with bisphosphonate drugs? Yes ☐ No ☐

Do you smoke or use smokeless tobacco?
Yes ☐ No ☐
If yes, how often? _________________________

Are you taking any medications? Yes ☐ No ☐
If yes, please list _________________________
____
____

Have you ever had joint replacement surgery?
Yes ☐ No ☐
If yes, when? ___________________________

Have you ever been hospitalized or had surgery?
Yes ☐ No ☐
If yes, please explain ______________________

Women: Are you pregnant? Yes ☐ No ☐
If yes, what is your due date _________________

Check any of the following that you have had or have at the present:

- ☐ Heart attack or stroke
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Pacemaker
- ☐ Chest pain (angina)
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Sickle cell disease or hemophilia
- ☐ Anemia
- ☐ Kidney trouble
- ☐ Arthritis
- ☐ Lupus
- ☐ Diabetes
- ☐ Emphysema
- ☐ Asthma
- ☐ Hepatitis A, B, or C
- ☐ Hypo/Hyperthyroidism
- ☐ Epilepsy
- ☐ HIV/AIDS
- ☐ Cancer/Tumour
- ☐ Psychiatric care
- ☐ Alcoholism
- ☐ Drug addiction
- ☐ Osteoporosis
- ☐ Autoimmune disease
- ☐ Radiation treatment to the head/neck

Do you have any diseases, conditions, or medical problems not listed above? Yes ☐ No ☐
If yes, please list ____

To the best of my knowledge the information provided above is correct. If there are changes to my health or medications I will inform the staff at my next appointment. I understand that payment is due upon services being rendered and that any balance not paid by my dental insurances is my financial responsibility

Date _____________ Signature ______________________________

Patient ☐ Parent ☐ Guardian ☐