ABACUS DENTAL CENTRE
DR. S. T. SOON INC., 604-826-1227

NAME _____

STREET _____

CITY _____ POSTAL CODE _____

PHONE-RESIDENCE # _____ CELL # _____

EMPLOYER _____ BUSINESS # _____

PERSON RESPONSIBLE FOR ACCOUNT _____

DATE OF BIRTH _____ AGE _____

PERSONAL PHYSICIAN _____ ADDRESS _____

HAVE DENTAL INSURANCE? Yes ☐ No ☐ INSURER _____

GROUP NO. _____ MEMBER'S ID NO. _____

REFERRED BY _____

MEDICAL HISTORY

The following information is required to thoroughly diagnose any condition and to give the highest possible standard of professional services. All information will be kept strictly confidential.

1. Are you now under the care of a physician? Yes ☐ No ☐
   (a) If so, what is the condition being treated?
   _____
2. Have you had any serious illness or operation? Yes ☐ No ☐
   (a) If so, what is the illness or operation?
   _____
3. Have you ever been hospitalized? Yes ☐ No ☐
   (a) If so, what was the problem?
   _____
4. Are you taking any drug or medicine? Yes ☐ No ☐
   (a) If so, what?
   _____
5. Are you **ALLERGIC** or have you reacted adversely to any drug or medicine: Yes ☐ No ☐
   e.g.. local anaesthetic (freezing); penicillin or other antibiotics; barbiturates, sedatives or analgesics (pain killers)?
6. Do you have or have you had any of the following diseases or problems?
   (a) Rheumatic fever or rheumatic heart disease? Yes ☐ No ☐
   (b) Congenital heart lesions? Yes ☐ No ☐
   (c) Cardiovascular disease: e.g. heart trouble; heart attack; high blood pressure; arteriosclerosis (hardening of the arteries); stroke? Yes ☐ No ☐
   (d) Chest pains or shortness of breath? Yes ☐ No ☐
   (e) Asthma, hay fever or skin rash? Yes ☐ No ☐
   (f) Fainting spells or seizures: e.g. epilepsy? Yes ☐ No ☐
   (g) Diabetes? Yes ☐ No ☐
   (h) Kidney disease? Yes ☐ No ☐
   (i) Hepatitis, jaundice or liver disease? Yes ☐ No ☐
   (j) Endocrine disorder: e.g. thyroid disease? Yes ☐ No ☐
   (k) Lung or breathing disorders: e.g. tuberculosis? Yes ☐ No ☐
   (l) Gastrointestinal disease: e.g. ulcers? Yes ☐ No ☐
   (m) Nervous disorder? Depression? Yes ☐ No ☐
   (n) Bone, muscle or joint disorders: e.g. arthritis? Yes ☐ No ☐
   (o) Cancer? Yes ☐ No ☐
   (p) H.I.V. (AIDS)? Yes ☐ No ☐
7. Have you ever had abnormal bleeding associated with previous dental extractions, surgery or trauma? Yes ☐ No ☐
   (a) Do you bruise easily? Yes ☐ No ☐
8. Do you have a blood disorder? Yes ☐ No ☐
9. Women: Are you pregnant? Yes ☐ No ☐
10. Do you have any disease or problem not listed above that I should know about? Yes ☐ No ☐
    (a) If so, please explain.
    _____
11. What dental condition concerns you at present? _____
    _____

PERMIT FOR DENTAL PROCEDURES

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures. Informed consent and financial approval authorized.

Patient's (Parent's) Signature _____ **Date** _____