DR. ANTHONY REA INC.

Oral and Maxillofacial Surgery

290-1641 Hillside Avenue
Victoria, B.C. V8T 5G1
Telephone: 250-370-7066
Fax: 250-370-1983

PATIENT INFORMATION

Today's Date: _____

Please circle: Dr Mr Mrs Ms Child M ☐ F ☐ Height: _____ Weight: _____

Patient's Name: _____ Birth Date: _____
(As it appears on Care Card) Month / Day / Year

Personal Health Number (Care Card): _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

****Appointments are confirmed through voice call, text, and email please provide appropriate info above**

Name of Dentist/Orthodontist: _____ Family Physician: _____

Emergency Contact Name and Phone #: _____

Have any family members attended our office previously? Yes ☐ No ☐ Name: _____

MEDICAL HISTORY

Please Print

List any prescription or non- prescription medications you take regularly: _____

_____

_____

List any surgeries you have had in the past: _____

_____

List any allergies or unusual reactions to medications, foods or environmental substances:

_____

_____

MEDICAL HISTORY CONTINUED

Please Print

Have you ever had an adverse reaction to local, deep sedation or general anaesthetic? Yes ☐ No ☐

Is there any familial history of sedation/anaesthetic complications? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐

WOMEN ONLY: Are you pregnant? Yes ☐ No ☐ If yes, when are you due? _____

Are you taking birth control? Yes ☐ No ☐ Are you breastfeeding? Yes ☐ No ☐

IF YOU HAVE EVER HAD ANY OF THE FOLLOWING CONDITIONS, PLEASE DESCRIBE:

Depression, Anxiety or other Mental/Emotional disorder: _____

Heart trouble, Chest pain, Congestive heart failure or Circulation disorder: _____

Endocarditis (infection of the heart valves) or any Heart valve disorders: _____

Heart rhythm disorder or Pacemaker: _____

Asthma or any other Lung disorder: _____

Liver disease or Hepatitis B or C: _____

Gastrointestinal disorder: _____

Kidney disorder: _____

Diabetes: _____

Thyroid disorder: _____

Stroke or other Brain injury: _____

Bleeding disorder or other Blood disorder (familial or yourself): _____

High blood pressure or Low blood pressure: _____

Epilepsy/Seizure disorder: _____

Muscle or Nerve disorders: _____

Cancer, Radiation and/or Chemotherapy: _____

Alcohol or Drug dependency: _____

Is there any problem or medical condition that you wish to discuss in private? Yes ☐ No ☐

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE CORRECT. IF THERE IS A CHANGE IN MY HEALTH HISTORY I WILL INFORM THE DOCTOR AT MY NEXT APPOINTMENT.

Date: _____ Signature of patient, parent or guardian: _____

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DENTAL INSURANCE INFORMATION

FIRST DENTAL PLAN:

Insurance Company: _____ Policy Holder's Employer: _____

Policy Holder's Name: _____ Policy Holder's Birth Date: _____

Certificate/ ID #: _____ Division # (if applicable): _____

Group/Policy #: _____ Dependent #: _____ Basic Dental Coverage: _____ %

SECOND DENTAL PLAN:

Insurance Company: _____ Policy Holder's Employer: _____

Policy Holder's Name: _____ Policy Holder's Birth Date: _____

Certificate/ ID #: _____ Division # (if applicable): _____

Group/Policy #: _____ Dependent #: _____ Basic Dental Coverage: _____ %

POLICY HOLDER'S ADDRESS (IF DIFFERENT FROM PATIENT'S ADDRESS):

_____

City: _____ Postal Code: _____ Phone: _____

PATIENT AUTHORIZATION

I authorize release, to my dental benefits plan administrator and the Canadian Dental Association, information contained in claims submitted electronically.

This authorization shall continue in effect until the undersigned revokes the same.

Signature of patient, parent or guardian: _____

Date: _____

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Anthony Rea Inc. and authorize payment directly to him.

This authorization shall continue in effect until the undersigned revokes the same.

Signature of subscriber: _____

Date: _____