West Coast Oral, Facial and Implant Surgery
Dr.Anthony Rea
290-1641 Hillside Avenue, Victoria BC V8T 5G1 T: 250.370.7066 F: 250.370.1983 E: referrals@westcoastos.com

PATIENT INFORMATION

Today's Date: _____

Please Circle: Dr Mr Mrs Ms Child M □ F □

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

PHN - (Care Card Number): _____ Height: _____Weight: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Home Phone:_____ Cell/Other Phone:_____

Email Address: (use parent or guardian's for patient's under 18): _____

Emergency Contact Name and Phone #: _____

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

Name of Dentist/Orthodontist: _____ Family Physician: _____

MEDICAL HISTORY

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: _____

_____

continued on reverse side

MEDICAL HISTORY CONTINUED

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 cigarettes / marijuana? How many per day? _____ Yes ☐ No ☐
Do you wear contact lenses? Yes ☐ No ☐

WOMEN ONLY: Are you pregnant? Yes ☐ No ☐ If yes, indicate due date: _____
Are you taking birth control? Yes ☐ No ☐ Are you breastfeeding? Yes ☐ No ☐

PLEASE DESCRIBE IN DETAIL IF YOU HAVE HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS:

Depression, Anxiety or other Mental/Emotional disorder: _____
Cardiac (chest pain, congestive heart failure, circulation disorder): _____
Endocarditis (infection of the heart valves) or any Heart Valve Disorders: _____
Heart Rhythm Disorder or Pacemaker: _____Cardiologist: _____
Asthma or any other Lung Disorder: _____
Obstructive Sleep Apnea _____Do you use CPAP?_____
Liver disease or Hepatitis B or C: _____
Gastrointestinal Disorder: _____
Kidney Disorder: _____ Nephrologist: _____
Diabetes (Type 1 or 2): _____ Endocrinologist: _____
Thyroid Disorder:_____
Osteoporosis: _____
Stroke or other Brain Injury:_____
Bleeding Disorder or other Blood Disorder (familial or yourself): _____
High Blood Pressure / Low Blood Pressure: _____
Epilepsy/Seizure Disorder: _____
Muscle or Nerve Disorders:_____
Cancer, Radiation and/or Chemotherapy:_____
Alcohol or Drug Dependency: (please describe)_____
Other: _____
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: _____

Group or Policy #: _____ ID #: _____

Dependent: □ Spouse □ Child □ Student – Name of School _____

PRIMARY POLICY HOLDER'S CONTACT INFO:

Address (if different than patient): _____

City: _____ Postal Code: _____ Phone: _____

Policy Holder's Email Address: _____

SECOND DENTAL PLAN:

Insurance Company: _____ Policy Holder's Employer: _____

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

Group or Policy #: _____ ID #: _____

Dependent: □ Spouse □ Child □ Student – Name of School _____

SECONDARY POLICY HOLDER'S CONTACT INFO:

Address (if different than patient): _____

City: _____ Postal Code: _____ Phone: _____

Policy Holder's Email Address: _____

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. When a claim is submitted as "pay dentist" 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 patient, parent or guardian Date