Wei Qian, D.M.D., M.Sc., Ph.D., F.R.C.D.(C) **David L. Hemerling**, D.M.D., F.R.C.D.(C) **Jeffrey M. Coil**, D.M.D., M.S.D., Ph.D., F.R.C.D.(C)

Kiarash Shabehpour, D.D.S., D.M.D., M.Sc., F.R.C.D.(C) **Ahmed Hieawy,** D.M.D., Ph.D., M.Sc. (Cons), M.Sc./Dip. Endo, F.R.C.D.(C)

Richmond Endodontic Associates

Certified Specialists in Endodontics

Richmond Health Sciences Centre #810-6091 Gilbert Rd, Richmond, BC, V7C 5L9 **(604) 270-8754** info@endobc.com

(The following confidential information is for our records only)

Name: _____ _____ _____ Date of birth: D_____/M_____/Y_____

Last name First name Middle Initial

Home Address: _____ _____ _____

Street City Postal Code

Home Phone: _____ Cell: _____ Business Phone: _____

Email: _____ Care card number: _____

Name of spouse, parent, or nearest relative: _____ Phone: _____

If patient is a **minor**, who is legally responsible: _____ Phone: _____

Referring Dentist: _____ Family Physician: _____

Insurance Information (if applicable):

Primary insurance company: _____

Group/policy #: _____

ID/Cert #: _____

Employer: _____

If primary coverage through spouse/partner, then please fill in:

Their name: _____

Date of birth: D_____/M_____/Y_____

Secondary insurance company: _____

Group/policy #: _____

ID/Cert #: _____

Employer: _____

Spouse/partner name: _____

Date of birth: D_____/M_____/Y_____

Dual Insurance Coverage for Children – requires both parent's birthdates:

Mother's date of birth: D_____/M_____/Y_____ Father's date of birth: D_____/M_____/Y_____

By signing below, I authorize the release of any information relating to dental claims, and understand that I am responsible for all the costs of dental treatment (we will submit the primary insurance claim and prepare any secondary claim forms on your behalf).**

Permission for Root Canal Treatment and Local Anaesthetic:

Upon being informed of all treatment options, I the undersigned, being the patient (or if a minor, the parent or guardian) consent to the performing of whatever procedure may be determined necessary by the Doctor. I authorize and request the administration of such medications and/or anaesthetics as may be deemed advisable by the Doctor. I also understand that upon completion of root canal therapy in this office, I will be referred back to my general dentist for a final permanent restoration, such as a permanent filling, onlay, or crown. Furthermore, **I understand that Richmond Endodontics Associates does NOT direct bill/collect any monies from my insurance plan, and full payment of all fees are due at the time of my appointment.**

Patient/Parent/Guardian signature: _____ Date: D_____/M_____/Y_____

Information and Medical History reviewed by: _____/_____

(staff) (doctor)

Medical History: Please answer the following questions. Your answers are for our records only, and considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Have you had any serious illness, operation, or been hospitalized in the past 5 years? If yes, what was the illness/reason? _____

Are you currently taking any medication? If yes, please provide list of medications: _____

Does your medical history include any of the following?: (*PLEASE CIRCLE ALL APPLICABLE CONDITIONS*)

☐ 1. Rheumatic or congenital (inborn) heart disease
☐ 2. Heart murmur, damage, or artificial heart valves. **If yes, do you require pre-medication**? _____
☐ 3. Cardiovascular disease (heart trouble, stroke)
☐ 4. **High** or **low** blood pressure. If yes, do you take medication? _____
☐ 5. Do you have a cardiac pacemaker?
☐ 6. Asthma, emphysema, or tuberculosis
☐ 7. Fainting, seizures, epilepsy, or neurological disorders
☐ 8. Diabetes
☐ 9. Hepatitis, jaundice, or other liver disease
☐ 10. Sexually transmitted disease
☐ 11. AIDS or HIV infection
☐ 12. Thyroid problems
☐ 13. Stomach ulcer
☐ 14. Kidney trouble
☐ 15. Mental health conditions
☐ 16. Cancer or treatment for tumor or growth?
☐ 17. Radiation therapy for cancer? Area of body treated: _____ Date: _____
☐ 18. Problems of the immune system?
☐ 19. Blood disorders (such as anemia) or abnormal bleeding?
☐ 20. Have had joint replacement surgery (knee, hip, etc.?) If yes, do you require pre-medicate?
☐ 21. Do you have any other illness or conditions not mentioned above? _____

Are you allergic or had any reaction to (please circle applicable):

☐ 22. Penicillin
☐ 23. Sulfa drugs
☐ 24. Aspirin, acetaminophen (Tylenol), or Ibuprofen (Advil, Motrin)
☐ 25. Codeine or other narcotics
☐ 26. Barbiturates, sedatives, or sleeping pills
☐ 27. Local anesthetics (novocaine)
☐ 28. Any other drugs or medications
☐ 29. Latex

For women patients:

Are you pregnant?: Yes☐ No☐ Are you nursing?: Yes☐ No☐

Please sign below to certify that you have answered each question to the best of your knowledge:

Patient/Parent/Guardian signature: _____ Date: D_____/M_____/Y_____

Click this button to email the form to our office. It will be sent via your default email program.
A copy of the completed form will be in your Sent Email folder.
If it doesn't work, please save the PDF to your computer and email to info@endobc.com

Email Form