Richmond Endodontic Associates
Certified Specialists in Endodontics

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

Confidential Patient Information:

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 parents' birthdates:

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

Patient/Parent/Guardian signature: _____Date: D_____/M_____/Y_____

Medical History:

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

- ☐ Penicillin, amoxicillin
- ☐ Sulfa drugs
- ☐ Latex (rubber)
- ☐ Codeine or other narcotics
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin, acetaminophen (Tylenol), or ibuprofen (Advil, Motrin), Naproxen (Aleve)
- ☐ Iodine
- ☐ Any other drugs or medications_____
  _____

Please turn page over →

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

☐ Are you presently under the care of a physician? (regularly for a specific medical condition) _____

_____

☐ Been a patient in the hospital in the last 5 years. If yes, what was the reason?_____

☐ Please list all medications you are currently taking (excluding vitamins and supplements) _____

_____

☐ Taking blood thinners. If yes, what are you taking?_____

☐ Currently or previously taking medication to treat osteoporosis or Paget's disease. If yes, what are you taking?

_____

☐ A physician/dentist has recommended that you require **antibiotic prophylaxis (premedication)** prior to dental procedures due to certain heart conditions, joint replacements, previous infective endocarditis, or other chronic illnesses.

☐ Had an unfavourable reaction following dental treatment or local anesthesia. If yes, please explain:

_____

☐ Jaw issues, including TMJD, grinding, clenching, or unable to open mouth for prolonged periods.

☐ Use any form of these substances: tobacco/nicotine products, vaping products, other controlled substances, including marijuana, for either medicinal or recreational reasons.

Heart health:

☐ Pacemaker/implanted defibrillator
☐ AFib or heart rhythm disorders
☐ Congenital heart disease
☐ Coronary artery disease
☐ Congestive heart failure
☐ Artificial heart valves
☐ Rheumatic heart disease
☐ Previous infective endocarditis
☐ Other heart conditions: _____

_____

Immune health:

☐ AIDS or HIV infection
☐ Autoimmune disease (lupus, etc.)
☐ Frequent infections

Blood health:

☐ Abnormal bleeding
☐ Anemia
☐ High or ☐ low blood pressure

Other conditions:

☐ Arthritis
☐ Asthma/COPD
☐ Diabetes
☐ Epilepsy/seizures/fainting
☐ Glaucoma
☐ Hepatitis, jaundice or liver disease
☐ High cholesterol
☐ Kidney problems
☐ Maxillary sinusitis

☐ Mental health conditions
☐ Neurological conditions
☐ Osteoporosis
☐ Rheumatoid arthritis
☐ Sexually transmitted infections
☐ Sleep apnea
☐ Stomach ulcers
☐ Stroke
☐ Thyroid problems
☐ Tuberculosis
☐ **Cancer:**

_____

☐ Radiation treatment
☐ Chemotherapy

☐ Other illness, condition, operation, or hospitalization not mentioned above, or further details of the above checked Yes:

_____

For female patients: ☐ Taking birth control pills ☐ Pregnant. Due date: _____ ☐ Nursing

☐ **Please check this box if <u>you do not have any medical conditions or take medications</u>.**

<u>Confirmation of payment agreement and medical history:</u>

I, the undersigned, agree that the above information is correct to the best of my knowledge, I authorize the release of any information relating to dental claims, and understand that I am responsible for all costs related to my dental treatment.
<u>I understand that Richmond Endodontics Associates does NOT direct bill/collect any money from my insurance plan(s), and full payment of all fees are due to Richmond Endodontic Associates at the time of my appointment.</u>

I certify that the medical history provided is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential to be hazardous to my health. I will not hold the dentist or any member of their staff responsible because of errors or omissions that I have made in completing my medical history form.

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

Reviewed by: Doctor signature _____