



Fairmont Dental Group
Dr. Andrew Cheng & Associates
 Suite 1906 — 805 West Broadway
 Vancouver, BC V5Z 1K1
 Phone: (604) 709-9001
 Website: <http://www.fairmontdental.com>
 E-mail: dentist@fairmontdental.com

Personal Information (All information is strictly confidential)

Last Name: _____ First Name: _____

Date of Birth: (Month/Day/Year) _____

M: F: Marital Status: Married Single Divorced Other

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: Home _____
Work _____ E-Mail Address: _____
Cell _____

Emergency Contact: _____

Emergency Contact Phone Number: () _____

Family Physician: _____ Phone: () _____

Referred by: _____

Account will be paid by: Dental Insurance Cash/Credit Card or Cheque

Dental Insurance Information

Name of Insurance Company: _____

Name of Employer: _____

Group/Policy Number: _____ Cert/ID Number: _____

Coverage: A. Basic: B. Major:

Financial Limit: _____

Please note: We will bill most dental plans directly on behalf of the patient. Please be advised this is for your convenience only, we are not liable or responsible for any portion not covered by your dental plan.

I, the undersigned, authorize dental treatment to be rendered by the dentist and him/her staff, and assume full financial responsibility at the end of each dental appointment regardless of insurance or any other third party involvement.

Signature of Patient: _____

Patient Medical History

Preferred Name: _____ Medical Alert: _____

Have you been under the care of a medical doctor during the past two years? Yes No

If Yes, for what? _____

Physician's Name: _____ Phone: _____

Address: _____ City: _____

Province: _____ PC: _____

Have you taken any medication or drugs during the past two years? Yes No

Are you taking any medication, drug or pills now, including regular dosages of aspirin? Yes No

Have you ever taken prescription medications for weight loss? (e.g. Fen-Phen) Yes No

If yes to any of the above, did you have a medical exam for heart issues? Yes No

Have you ever taken prescription medications for osteoporosis prevention? Yes No

If yes, did you take any Fosamax or Aredia (Bisphosphonate)? Yes No

Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No

If yes, please list: _____

Have you been a patient in the hospital during the past five years? Yes No

Indicate which of the following you have had, or have at present. Check "yes" or "no" for each item.

Heart (Surgery/Disease/Attack) Yes No Ulcers Yes No

Hepatitis A (infectious) Yes No Chest Pain Yes No

Hepatitis B (serum) Yes No

Diabetes Yes No Venereal Disease Yes No

Congenital Heart Disease Yes No Thyroid Problem Yes No

A.I.D.S Yes No Heart Murmur Yes No

Glaucoma Yes No H.I.V. Positive Yes No

High Blood Pressure Yes No Contact Lenses Yes No

Cold Sores/Fever Blisters Yes No Mitral Valve Prolapse Yes No

Emphysema Yes No Blood Transfusion Yes No

Artificial Heart Valve Yes No Chronic Cough Yes No

Hemophilia Yes No Heart Pacemaker Yes No

Tuberculosis Yes No Sickle Cell Disease Yes No

Rheumatic Fever Yes No Asthma Yes No

Bruise Easily Yes No Arthritis/Rheumatism Yes No

Hay Fever Yes No Liver Disease Yes No

Cortisone Medicine Yes No Latex Sensitivity Yes No

