New Patient Form

WEST COAST
ORAL & MAXILLOFACIAL SURGERY

Patient's Name: *(Last)* _____ *(First)* _____

Phone: *(H)* _____ *(W)* _____ *(C)* _____

Email: _____ Emergency Contact: _____ Phone: _____

Address: _____ *(City)* _____ *(Postal Code)* _____

Date of Birth: *(DD / MM / YYYY)* _____ Age: _____ Weight: _____ Gender: _____

CareCard: *(#)* _____ Medical Doctor: _____ Phone: _____

Your dentist is: _____ Phone: _____

Who referred you to our office: _____

DENTAL INSURANCE		
Primary Insurance Carrier:	*Policy #*	*ID #*
Plan Holder's Name:	*Dependant #*	*Policy Holder's DOB:*
Second Dental Insurance Carrier:	*Policy #*	*ID #*
Plan Holder's Name:	*Dependant #*	*Policy Holder's DOB:*

DO YOU HAVE	YES	NO	NOT SURE	COMMENTS
Any history of major surgery?	○	○	○	*Specify:*
Any Anesthetic problems relating to any surgery?	○	○	○	*If yes, explain:*
Any heart problems or heart murmur?	○	○	○	*Specify:*
Have you ever tested **positive** for **HIV**?	○	○	○	☐ *Treated* ☐ *Not treated*
Have you ever tested **positive** for **Hepatitis A, B, C?**	○	○	○	
Diabetes?	○	○	○	☐ *Insulin* ☐ *Diabetic pills* ☐ *Diet controlled*
TMJ (jaw) problems?	○	○	○	*If yes, explain:*
Do you take blood thinners? (Aspirin or Coumadin/Warfin etc)	○	○	○	*Why?:*
Do you take medication for Osteoporosis (e.g. Fosomax, etc)	○	○	○	
Any Stomach or intestinal disorders?	○	○	○	
ANY DRUG ALLERGIES	○	○	○	*Please list:*
ANY food or environment allergies	○	○	○	*Please list:*
Are you a smoker? (e.g. cigarettes, cigars, pipe, vape)	○	○	○	*Specify:*
Do you use marijuana / cannabis products?	○	○	○	*Form taken:* *How often:*
Are you now taking **ANY** drugs or medication or Anti-Depressants?	○	○	○	
Women: Are you pregnant or is there a possibility you might be?	○	○	○	
Women: Are you taking birth control pills?	○	○	○	
Do you have any medical/dental condition or drug use you wish to discuss in private?	○	○	○	

DO YOU HAVE	YES	NO		YES	NO		YES	NO
Asthma	○	○	Shortness of Breath	○	○	Tuberculosis	○	○
Rheumatic Fever	○	○	Glaucoma	○	○	Cancer	○	○
Convulsive Seizures	○	○	Bleeding Problems	○	○	High Blood Pressure	○	○

Patient Heath Questionnaire completed by: ○ *Patient* ○ *Family member* ○ *Health care provider* | *Other:* _____

Print Name(s): _____ Signature _____ Date *(DD / MM / YYYY):* _____

Office Use Only

WEST COAST
ORAL & MAXILLOFACIAL SURGERY

Patient Name: *(Last, First)* _____ *(Phone #)* _____

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18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
			55	54	53	52	51	61	62	63	64	65			
			85	84	83	82	81	71	72	73	74	75			

Dr. S	Dr. B

TODAYS APPOINTMENT			
□ Consult	□ PAN	□ PA	□ CT
Treatment Plan			
□ Extraction:			
□ Graft:			
□ CT & Impression:			
□ Implant:			
□ Lesion:			
□ Sinus:			
□ IV:			
□ Other:			
Follow Up			
□ Refer to:			
□ Discuss Case With:			

Yaletown
#209 - 179 Davie Street, Vancouver, BC V6Z 2Y1
p 604-688-7781 **f** 604 683 2203
e vancouver@westcoastoralsurgery.ca

Port Coquitlam
#230 - 2755 Lougheed Hwy, Port Coquitlam, BC V3B 5Y9
p 604-464-6833 **f** 604 464 3168
e portcoquitlam@westcoastoralsurgery.ca

North Vancouver
#370 - 138 E 13th Street, North Vancouver, BC V7L 0E5
p 604-416-2670 **f** 604 416 2678
e northvancouver@westcoastoralsurgery.ca

Dr. A. Sadeghi | Dr. T. Barr
Certified Specialists in Oral & Maxillofacial Surgery

WESTCOASTORALSURGERY.CA