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/Pronoun: _____

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
Please list **ALL** previous surgeries				
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** medication?				*Please list:*
Women: Are you pregnant or is there a possibility you might be?				
Women: Are you taking birth control pills?				
Are there any other known medical conditions not listed on this form?				

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 Health 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** **Dr. F**

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

Yaletown
#209 - 179 Davie Street, Vancouver, BC V6Z 2Y1
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p 604-464-6833 **f** 604 464 3168
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