Welcome to Dr. Ben Kang Oral & Facial Surgery

office only:

Photo/Alerts Updated ☐

First Name: ____________________ **Last Name:** ______________________

Preferred name: ____________________ **PH Care Card #:** ____________________

Date of Birth: Day ____________ **Month** ______________ **Year** ______________

Address: ____

City: ______________________ **Province:** __________ **Postal Code:** __________

Home Phone: ____________________ **Cell Phone:** ______________________

Business Phone: _________________________ **E-mail:** ____________________

Employer: _________________________ **Occupation:** ____________________

In case of emergency, please notify:_______________ **Relationship:**_______________ **Phone:**_______________

IF undergoing sedation, who will be responsible for taking you home? Name: _______________ **Phone:** _______________

Who is responsible for paying any cost not covered by insurance for this account? ________________________________

MEDICAL AND HEALTH CONDITIONS:

My last medical examination was on (approximate) ____________________

Are you under the care of a physician? __________ ☐ Yes ☐ No

Name of your physician: ______________________ Address: ______________________________

Have you been hospitalized within the past 5 years? ☐ Yes ☐ No If yes, please explain why ________________

Are you currently taking any medication, prescription or non-prescription? Please list:

Drug: ____________ Purpose: ____________ Drug: ____________ Purpose: ____________

Drug: ____________ Purpose: ____________ Drug: ____________ Purpose: ____________

Previous drug therapy ____

Previous unusual reactions or responses to drugs ______________________________

Previous anesthetic experience including problems or complications ______________________

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	Heart problems ____________	☐	☐
2.	Heart murmur ____________	☐	☐
3.	Rheumatic fever ____________	☐	☐
4.	High blood pressure ____________	☐	☐
5.	Stroke ____________	☐	☐
6.	Artificial prosthesis i.e. heart valve/joint	☐	☐
7.	Anemia or other blood disorders ______	☐	☐
8.	Prolonged bleeding due to slight cut ___	☐	☐
9.	Emphysema ____________	☐	☐
11.	Kidney disease ____________	☐	☐
12.	Liver disease ____________	☐	☐
13.	Jaundice ____________	☐	☐
14.	Thyroid or parathyroid disease ______	☐	☐
15.	Hormone deficiency ____________	☐	☐
16.	Diabetes ____________	☐	☐
17.	Psychiatric treatment ____________	☐	☐
18.	Osteoporosis i.e. taking Bisphosphonate	☐	☐

		YES	NO
19.	Alcohol/drug dependency ________	☐	☐
20.	Stomach or duodenal ulcer ________	☐	☐
21.	Digestive disorder, i.e. gastric reflux ___	☐	☐
22.	Low blood pressure ________	☐	☐
23.	Arthritis ________	☐	☐
24.	Glaucoma ________	☐	☐
25.	Epilepsy or convulsions (seizures) _____	☐	☐
26.	Neurologic problem ________	☐	☐
27.	Viral infections and cold sores ______	☐	☐
28.	Any lumps or swelling in the mouth ___	☐	☐
29.	Hives, skin rash, hay fever ________	☐	☐
30.	Venereal disease ________	☐	☐
31.	Hepatitis (type ___) ________	☐	☐
32.	HIV/AIDS ________	☐	☐
33.	Tumor, abnormal growth ________	☐	☐

Do you need antibiotics <u>before</u> for your dental treatment? (told by physician) _ ☐ Yes ☐ No
Do you smoke? ______ ☐ Yes ☐ No
Do you take any pill to strengthen your bones? ______ ☐ Yes ☐ No
Do you have any allergic reaction to a medication that we should be aware of? _ ☐ Yes ☐ No
Do you have any allergy to:
Penicillin ______ ☐ Yes ☐ No
Latex ______ ☐ Yes ☐ No
Anesthetic ______ ☐ Yes ☐ No
Metal ______ ☐ Yes ☐ No
Any other allergy ______ ☐ Yes ☐ No
Strong family history of stroke/heart attacks ______ ☐ Yes ☐ No
Any other medical information we should know? ______ ☐ Yes ☐ No
Or any disease, condition or problem not listed above? ______ ☐ Yes ☐ No

Women

Are you taking birth control pills? ______ ☐ Yes ☐ No
Are you presently pregnant/missed a menstrual period/ breast-feeding ______ ☐ Yes ☐ No

I, ______________________ do hereby consent to the release of dental /medical information , including records & X-Rays to Langley Oral Surgery. I authorize the release, to my insuring company, the information contained in claims submitted electronically. I consent to the dental treatment agreed upon. I am responsible for payment of the corresponding fees at date of service. I acknowledge that any fees **<u>NOT</u>** paid by my insurance company are my responsibility which may result in a separate bill after insurance pays the dentist & estimates are subject to change due to unforeseen treatment. I am aware that Langley Oral Surgery will bill my insurance as a <u>courtesy</u>; however they are not responsible for my plan i.e.: any limits & may not know my information due to the Privacy Act of B.C. I understand that a possibility of complications exists for each treatment.

In addition, **<u>48 hours' notice is required for an appointment change</u>** otherwise a $75 cancellation fee will apply.

<u>I have carefully read and understand the terms policies as described above.</u>

Date: ______________________ Signature: X ______________________