Vancouver Native Health Society

Date: _____ / **PAGE 1 OF 2**

LAST NAME: _____ FIRST NAME: _____

DOB (mm/dd/yy) _____ PHONE#: _____EMAIL _____

CARE CARD # _____ NATIVE STATUS CARD # _____

OTHER ID# (PAROLE, REFUGEE STATUS#): _____

ARE YOU UNDER: INCOME ASSISTANT / EI / DISABILITY / HEALTHY KIDS PROGRAM / WCB

MEDICAL CLINIC LAST SEEN _____

REASSON OF VISIT TO MEDICAL CLINIC _____

CONTACT INFO OF YOUR MEDICAL DOCTOR _____

Are you allergic to any of the following?

- Aspirin ☐
- Penicillin ☐
- Codeine ☐
- Local anaesthetics ☐
- Acrylic ☐
- Metal ☐
- Latex ☐
- Dust/pollen ☐
- Sulpha drugs ☐
- `Others _____ _____

Women only: Are you?

- Pregnant Yes ☐ No ☐
- Trimester? _____
- Taking oral contraceptives Yes ☐ No ☐
- Nursing Yes ☐ No ☐

SERIOUS ILLNESS (check more than one if needed)

- AIDS/HIV positive ☐
- Alzheimer's Disease ☐
- Anaphylaxis ☐
- Anaemia ☐
- Angina ☐
- Arthritis/Gout ☐
- Artificial Heart Valve ☐
- Artificial Joint ☐
- Asthma ☐
- Blood Disease ☐
- Blood thinners ☐
- Breathing Problem ☐
- Bruce Easily ☐
- Cancer ☐
- Chemotherapy ☐
- Chest Pain ☐
- Coagulation problems ☐
- Cold Sore/Fever Blisters ☐
- Congenital Heart Disorder ☐
- Convulsions ☐
- COPD ☐
- Depression ☐
- Diabetes ☐
- Drug addiction ☐
- Easily winded ☐
- Emphysema ☐
- Epilepsy or seizures ☐
- Excessive bleeding ☐
- Excessive thirst ☐
- Fainting spells/dizziness ☐
- Frequent cough ☐
- Frequent diarrhea ☐
- Frequent headaches ☐
- Genital herpes ☐
- GI problems ☐
- Glaucoma ☐
- Hay fever ☐
- Heart attack/failure ☐
- Heart murmur ☐
- Heart pacemaker ☐
- Heart trouble/disease ☐
- Haemophilia ☐
- Hepatitis A ☐
- Hepatitis B or C ☐
- Herpes ☐
- High Blood Pressure ☐
- High Cholesterol ☐
- Hives or Rash ☐
- Hypoglycaemia ☐
- Irregular heart beat ☐
- Kidney Problems ☐
- Liver Disease ☐
- Low blood pressure ☐
- Lung disease ☐
- Mitral valve prolapsed ☐
- Osteoporosis ☐
- Pain in jaw joints ☐
- Parathyroid disease ☐
- Psychiatric care ☐
- Radiation treatments ☐
- Recent weight loss ☐
- Renal dialysis ☐
- Rheumatic fever ☐
- Rheumatism ☐
- Scarlet fever ☐
- Shingles ☐
- Sickle cell disease ☐
- Sinus trouble ☐
- Spine bifida ☐
- Stress drugs addictions ☐
- Stroke ☐
- Swelling of limbs ☐
- Thyroid problems ☐
- Tonsillitis ☐
- Tuberculosis (TB) ☐
- Tumour or growths ☐
- Ulcers ☐
- Venereal Disease ☐
- Yellow Jaundice ☐

Have you ever had any serious illness not listed above? Yes ☐ No ☐

_____

_____

455 East Hasting St, Vancouver BC V6A 1P5.
T. 604.254.9900 / F. 604.254.9980 / E. dentalclinic@vnhs.net

Are you taking any current medication? (Including pain killers and antibiotics) Yes □ No □

_____

_____

_____

_____

Do you need any prescription prior any dental treatment? _____

Do you know your last BLOOD PRESSURE LEVELS? _____

Have you taken any BLOOD TEST RECENTLY? _____

Do you know your last SUGAR LEVEL? _____

STREET DURGS/ADDICTIONS last used _____

RECOVERY PROGRAM/METHODONE dosage/how long _____

WAIVER – RELEASE CONSENT

I _____ recognize that my dental care might need immediate treatment and it will require to take into consideration my physical / medical condition. I hereby affirm that I am in a good physical condition and do not suffer from any known disability or condition which would prevent or limit my treatment at the office.
I further understand that I have been advised of alternative treatments for my condition and the specific risks and complications related to it. Therefore, I completely acknowledge; that all my questions have been answered to my satisfaction.

I also acknowledge:

1. That I provided all the information needed to asses my physical health and/or I provided the information needed to contact my Family Doctor.
2. The Dentist/Surgeon is able to administrate the anaesthetics needed for my treatment.
3. That I am under no pressure to sign this consent and I am 100% under full control of my actions, hereby I release the VANCOUVER NATIVE HEALTH SOCIETY – DENTAL CLINIC and its agents from any liability now or in the future for conditions that I may obtain. These conditions may include, but are not limited to, medical or dental complications related to the treatment received.

Patient Signature: _____

Guardian: _____

Date: _____