



**Dr. Zina Sarsam Inc.**  
**104-6411 Nelson Avenue**  
**Burnaby, B.C. V5H 4H3**  
**Tel: 604-431-0202**

**PATIENT** Last Name: ..... First: ..... Date of Birth: .....  
 Address ..... City ..... Province ..... P.C .....  
 Telephone (Mobile) ..... (Work) ..... (Home) .....  
 Email ..... How did you hear about our practice? .....  
 Employed by ..... Occupation .....  
Spouse Last Name: ..... First: ..... Phone # .....  
 \* **RESPONSIBLE PARTY** (If minor) Last Name: ..... First: .....

**EMERGENCY CONTACT**

Last Name: ..... First: ..... Phone# .....

**INSURANCE INFORMATION**

<u>Primary Insurance</u>	<u>Secondary Insurance</u>
Insurance Company: .....	Insurance Company: .....
Insurance Policy # .....	Insurance Policy # .....
Subscriber ID # .....	Subscriber ID # .....
Subscriber Name.....	Subscriber Name.....
Subscriber Address .....	Subscriber Address .....
City ..... Province ..... P.C .....	City ..... Province ..... P.C .....
Date of Birth: .....	Date of Birth: .....
Relationship to Subscriber <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child	Relationship to Subscriber <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child

Please, present your insurance card to be photocopied for our records.

**AUTHORIZATION**

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and **understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.**

Your appointment is for your exclusive use, **so any missed appointments or cancellations with less than 48 business hours notice will result in a cancellation charge.**

**Signature** ..... **Date** .....  
 (Responsible Party, if under 19)



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**MEDICAL HISTORY**

Physician's name ..... Care card # .....

Have you had any serious illnesses or operations?  Yes  No If yes, please describe .....

*Please check if you have/had:*

	Yes	No		Yes	No		Yes	No
High/low blood pressure			Allergies, hay fever, sinusitis			Anemia		
Diabetes			Arthritis, Rheumatism			Bleeding abnormally with operations or surgery		
Artificial heart valves			Circulatory problems			Do you take Aspirin?		
Stroke			Cortisone treatments			Blood disease, clotting disorders		
Heart murmur			Cough, persistent or bloody			Hepatitis type .....		
Pacemaker			Sinus trouble			Any immune deficiency		
Mitral valve prolapses			Skin rash			Kidney disease		
Shortness of breath			Slow healing wounds			Osteoporosis		
HIV			Respiratory disease			Radiation treatments		
Asthma			Herpes			Tuberculosis		
Cancer			Rheumatic fever			Tumor or growth on head/neck		
Chemotherapy			Emphysema			Venereal disease		
Artificial joints			Epilepsy			Are you currently under the care of a Physician?		
Swelling of feet or ankles			Glaucoma			Are you allergic/sensitive to Latex?		
Thyroid problems			Scarlet fever			Do you consume alcoholic beverages?		

**Allergic** to Penicillin, Aspirin, or other drugs? If yes please, specify .....

List any **medications** that you are taking: ..... // ..... // .....

**Women:** Are you pregnant? Yes  No  Due date ..... Nursing? Yes  No  Taking birth control pills? Yes  No

**DENTAL HISTORY**

Former Dentist ..... Date of last dental visit .....

How often do you see your hygienist:  3months  6months  9months? last Hygiene visit: .....

*Please, Check if you have/had:*

	Yes	No		Yes	No		Yes	No
Bad breath			Blisters on lips or mouth			Clench or grind teeth		
Dental Implant			Burning sensation on tongue			Head, neck, jaw pain, or aches		
Denture			Cigarette, pipe, or cigar smoking			Loose teeth or broken fillings		
Dry mouth			Food collection between teeth			Mouth breathing		
Gum Surgery			Gums swollen, tender or bleeding			Orthodontic treatment		
Face or Jaw Injury			Do you floss? How often? .....			Sensitivity to pressure or irritants (cold, heat, sweets)		
			Do you brush? How often? .....			Allergic reaction to Novocaine, local, general anesthetics?		
						If Yes, please explain .....		

\* I the undersigned, acknowledge that all of the medical and dental information provided is true, and that I have not knowingly omitted any information. I also consent to my physician being contacted if necessary for information that may be required for treatment.

**Signature:** ..... **Date:** .....  
 (Responsible Party, if under 19)

**Reviewed By:** ..... **Date:** .....