CATHEDRAL DENTAL CENTER
Dr. Sungho Jun

Patient Information:

Name:_____Address: _____
(First, Middle, Last)
Apt:_____ Postal Code: _____ Parent's Name(If Child): _____

Home Phone: _____ Business: _____ Cell: _____

Birth Date: D)_____ M) _____ Y) _____ Email: _____

Health Card # _____

Treaty Number: _____ Band Name: _____

Do You Have Dental Insurance? _____ Employer: _____

What is the main purpose of today's visit? _____

Would you like a complete dental exam today? _____ A dental cleaning? _____

How did you hear about Cathedral Dental Center? _____****

Cash_____ Credit Card_____

Debit_____ Insurance_____

Note: If you are assigning benefits from your insurance company, you must leave a credit card number or pay a $25.00 insurance deposit that will be returned after all insurance claims are settled.

Acknowledgement and Consent: I _____
Acknowledge reviewing the Cathedral Dental Center Privacy Policy posted in the waiting room and I understand my rights of privacy with respect to personal information.

OVER

Are you under a doctor's care for anything? _____ What condition? _____ if you are taking medications, list the medications and the conditions for which you are taking them for:

Condition: _____ Medication: _____

Condition: _____ Medication: _____

Do you have?

Asthma	yes ( )	no ( )
Diabetes (high blood sugar)	yes ( )	no ( )
High Blood Pressure	yes ( )	no ( )
Low Blood Pressure	yes ( )	no ( )
Are you Anemic	yes ( )	no ( )
Do you get short of breath	yes ( )	no ( )

Did you ever have any of the following?

Hepatitis	yes ( )	no ( )
TB	yes ( )	no ( )
Rheumatic Fever	yes ( )	no ( )
Cancer	yes ( )	no ( )
Seizures	yes ( )	no ( )
Epilepsy	yes ( )	no ( )
Heart Valve Replacement	yes ( )	no ( )
Artificial Joints	yes ( )	no ( )
Kidney Transplant	yes ( )	no ( )
HIV	yes ( )	no ( )
Drug allergies	yes ( )	no ( )
(To what drugs?)	_____ _____ _____	

Do you bleed excessively if you are cut? _____
Are you **pregnant**? _____If so how many months? _____
Have you ever had an unusual reaction to dental "freezing"? _____
If so what was the reaction? _____
Have you ever had trouble with dental extractions? _____
If so, describe the problems? _____
Do you have a **heart condition**? _____
If so, what is the condition? _____

Date: _____ I consent to dental treatment required.

Signature: _____ OR Guardian: _____