DOVE
DENTAL

Dr. Peter Becher Inc.
Tel: (604) 589 - 7877
#202 - 15135 101 Ave.
Surrey, BC V3R 7Z1

PATIENT INFORMATION

PATIENT`S ◯ Mr. ◯ Mrs.

NAME ◯ Ms. ◯ Dr. _____
Last First Middle

Please circle the name you prefer to be called

Home Address _____ Date of Birth _____

City _____ Province _____ Postal Code _____

Home Phone No. _____ Work Phone No. _____

Your Employer _____ Occupation _____

Business Address _____

Your Physician _____ Physician Phone No. _____

Whom may we thank for referring you? _____

Your Nearest Relative _____ Phone No. _____

E-mail Address _____

FINANCIAL RESPONSIBILITY

Payment is accepted at the time service is rendered. We are happy to provide you with an estimate. You may pay your account by Cash, Visa, Mastercard, Cheque, Dental Insurance or Government Plan. The following Dental Insurance information helps us process your claims and assists you in beller utilizing your insurance benefits.

Do you have Dental Insurance: ◯ yes ◯ no Insurance Co. _____

Coverage No._____

Insured Persons Name _____ Social Ins. No. _____

Provo Health Care No. _____ Social Assis. No. _____

MEDICAL HISTORY

Have you ever had a serious injury or major operation? _____

If yes, what and when? _____

Are you in good health now? _____

Are you presently being treated by a physician? _____

Are you taking any medications, pills, drugs or medicine? _____

If yes, please list _____

Do you now have or have you ever had any of the following?

- ☐ Heart Trouble or Stroke
- ☐ Hepatitis, Jaundice, Liver Disease
- ☐ Drug allergies or reactions
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Rheumatic Fever
- ☐ Bleeding problem or blood disorder
- ☐ High or Low Blood Pressure
- ☐ Chest Pains, Shortness of Breath
- ☐ Epilepsy or Seizures
- ☐ Diabetes
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Nervous
- ☐ Asthma or allergies
- ☐ Cancer
- ☐ Frequent headaches
- ☐ HIV/AIDS

Women: Are you pregnant: ☐ yes Due date _____

Are you presently being treated by a physician? _____

ALLERGIES

Have you ever had a reaction to:

☐ Penicillin ☐ Local Anaesthetic (Freezing) ☐ General Anaesthetic
☐ Codeine ☐ Aspirin ☐ Other (Specify) _____
☐ Metals or Jewellery

Is there anything else we should know about your health? _____

Please specify _____

DENTAL HISTORY

What dental condition concerns you at present? _____

When was your last visit to a dentist? _____

When was your last cleaning? _____

Do you have any sore, aching, or sensitive teeth?	○ Yes	○ No
Do you have any pain elsewhere in your face or jaws?	○ Yes	○ No
Do you have any loose teeth?	○ Yes	○ No
Do you grind or clench your jaws or teeth during the day or night?	○ Yes	○ No
Does food catch frequently between any of your teeth?	○ Yes	○ No
Have you ever had any complications with local anaesthetic (freezing)?	○ Yes	○ No
Would you like to improve the appearance of your teeth?	○ Yes	○ No

CONSENT

I authorize the Dental Personnel to perform services for prevention and treatment of dental disease using the procedures and medications required, and assume responsibility for the fees associated with those procedures.

Date _____ Signature of Patient or Parent _____

Are you available on short notice? ○ Yes ○ No Same Day ○ Yes ○ No