BELLEVILLE SLEEP DENTISTRY
Dr. Michael Chow, Board Certified Dentist-Anaesthesiologist
222 Bell Blvd., unit 6, Belleville, ON K8P 5L7
☎ 613-962-7773 🖷 613-962-7778 ✉ bellevillesleepdentistry@hotmail.com

NEW PATIENT INFORMATION

CONTACT INFORMATION

Patient (First name, Last name): _____ Sex: M / F Age:_____ Date of Birth:____/____ /_____
Day Month Year

Address:_____ Unit: _____ City:_____ Postal Code:_____

Home Phone ( )_____ Work Phone ( )_____ext:_____ Cellphone ( )_____

Email Address: _____

Emergency Contact: _____ Phone ( )_____ Relationship to patient: _____

• *Who will be responsible for taking you home after anaesthesia?* **A taxi driver alone is not sufficient.**

Name: _____ Phone ( )_____ Relationship to patient: _____

Family Dentist: _____ Phone ( )_____ Fax ( )_____

For children and dependant adults only:

Parent or Guardian (First name, Last name):_____ Work / Cellphone ( )_____

Parent or Guardian (First name, Last name):_____ Work / Cellphone ( )_____

FINANCIAL INFORMATION

Who is the person responsible for the account/ payments?

Name: _____ Relationship to patient: _____ Home Phone ( )_____

Employer: _____ Position: _____ Work Phone ( )_____ext:_____

INSURANCE INFORMATION:

• Primary Insurance Co:_____ Policy Number:_____ Certificate Number:_____

Subscriber Name: _____ Date of Birth: ____ / ____ / ____ Relationship to patient:_____
Day Month Year

Name of employer insurance is through:_____

• Secondary Insurance Co:_____ Policy Number:_____ Certificate Number:_____

Subscriber Name: _____ Date of Birth: ____ / ____ / ____ Relationship to patient:_____
Day Month Year

Name of employer insurance is through:_____

MEDICAL CARE INFORMATION

• Family Physician: Dr._____ Phone ( )_____ Fax ( )_____

Address:_____ Unit: _____ City:_____ Postal Code:_____

• Pharmacy: _____ Phone ( )_____ Fax ( )_____

I certify to the best of my knowledge that the information above is true, correct and complete.
I authorize release, to my dental benefit plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to Dr. Michael Chow. This authorization shall continue in effect until the undersigned revokes the same.

Signature: _____ Print:_____ Relationship to patient:_____ Date: _____

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PRE-ANAESTHESIA QUESTIONNAIRE

Patient Name: _____ Age: _____ Weight: _____ Height: _____

		Yes	No	Not Sure
1.	Do you have any health problems or concerns presently?	☐	☐	☐
2.	Has there been ANY change in your general health in the past year?	☐	☐	☐

If yes, please explain: _____

How often do you see your family doctor? Every___ months. Last complete physical exam? _____/_____
month year

3.	Have you ever been in hospital for treatment?	☐	☐	☐

When, where and why? _____

4.	Have you ever had general anaesthesia or surgery?	☐	☐	☐

Where, when and why? _____

Were there any problems with the anaesthesia? _____

5.	Have you or any of your family relatives had problems with anaesthesia?	☐	☐	☐

Please explain._____

Were any tests done? _____

6.	Do you have a drug allergy? What drug(s)?_____	☐	☐	☐

What year?_____ What happened? (Circle) rash breathing problems/wheezing swelling

7.	Do you have any other allergies (e.g. latex)? _____	☐	☐	☐
8.	Do you take ANY medications (including puffers and birth control)? Please list all of your medications:	☐	☐	☐

Name / Dose: _____ Name / Dose: _____
Name / Dose: _____ Name / Dose: _____
Name / Dose: _____ Name / Dose: _____

9.	Do you use or take ANY non-prescription remedies (including herbal)?	☐	☐	☐

Name: _____ Name: _____

10.	Have you taken cortisone (steroid) type drug orally in the past year? Drug name/ dose: _____	☐	☐	☐

When and why?_____ How long were you taking it for?_____

11.	Do you or any of your relatives have a bleeding problem?	☐	☐	☐
12.	Do you have or have had any difficulty breathing through your nose?	☐	☐	☐
13.	Do you have nose bleeds? If so, how many per week?_____	☐	☐	☐
14.	Do you have or have had any difficulty breathing while sleeping?	☐	☐	☐
15.	Can you walk up 2 flights of stairs or 2 city blocks quickly without resting?	☐	☐	☐

16. Please rate how anxious you are about dental exams and/or treatment (Please circle):

Very relaxed 1 2 3 4 5 Extremely Anxious

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PRE-ANAESTHESIA QUESTIONNAIRE cont'd

Patient Name: _____

17. Do you have or have had any of the following?

	Yes	No	Not sure			Yes	No	Not sure
Heart Murmur					Fainting spells, dizziness			
Heart attack					Diabetes			
Chest pain or angina					Thyroid problems			
Shortness of breath lying down					Adrenal gland problems			
Swollen ankles					Hepatitis			
Heart pacemaker/defibrillator					Liver disease/jaundice			
Irregular heart beat/arrhythmia					Anemia (including sickle cell)			
High blood pressure					Blood disorders/transfusions			
Congenital Heart disease					Bleeding (coagulation) disorders			
Damaged/abnormal heart valves					Stomach ulcers/ acid reflux			
Rheumatic fever					Bone, joint, or muscle problems			
Kidney disease					Artificial joints (hips, knees)			
HIV, AIDS, or STD					Arthritis			
Malignant hyperthermia					Depression/anxiety			
Pseudocholinesterase deficiency					Vision problems/Glaucoma			
Cancer/Chemotherapy					Mentally disabled			
Sleep apnea					Cerebral palsy			
Asthma					Autism or Down's syndrome			
Emphysema/Bronchitis					**WOMEN:**			
Cystic fibrosis/Tuberculosis					Are you pregnant?			
Epilepsy					Are you a nursing mother?			
Stroke					Any problems with menstruation?			

	Yes	No	Not sure
18. Do you ever have episodes of blurred vision or black spots or experience weakness or paralysis on one side of your body, arms, legs or face?	☐	☐	☐
19. Do you have any problems opening your mouth wide or moving your neck fully?	☐	☐	☐
20. Have you ever had surgery, radiation or chemotherapy treatment for a tumour or cancer? If so, please explain _____	☐	☐	☐
21. Do you smoke or chew tobacco? If so, how much? _____	☐	☐	☐
22. Do you drink more than 5 alcoholic beverages per week? Number per week _____	☐	☐	☐
23. Do you have a history of alcoholism or drug dependence?	☐	☐	☐
24. Have you taken "recreational drugs" in the past year such as marijuana, LSD, PCP, cocaine, crack, crystal meth, codeine, oxycodone or other drugs?	☐	☐	☐
25. Do you have ANY disease, condition or problem not listed above? _____	☐	☐	☐

26. Additional comments: _____

I certify to the best of my knowledge that the information above is true, correct and complete. I authorize Dr. Michael Chow's office to contact my dentist and/or physician as necessary. This authorization shall continue in effect until the undersigned revokes the same.

Signature: _____ Print:_____ Relationship to patient:_____ Date: _____