BURNABYSQUARE DENTAL Dr.ShahramKamaei D.D.S.

Name: Address: Phone:

Date of Birth: Email: PHN#: Emergency Contact#:

SURVEY

1. **How did you find us?**

2. **How satisfied are you with your smile?**

3. **How nervous are you when it comes to dental appointments?**

4. **What is the most important factor in choosing a dental office?**

OFFICE POLICIES

1. **Cancellation with less than 24 hours of notice will be charged at $75/hour for appointments.**
   INITIAL:

2. **If after 90 days your insurance does not respond with payments you are personally responsible for those shortcomings, this means we have worked hard to get the payment(s) several times already, and we are happy to give you all the necessary claims for you to follow up.**
   INITIAL:

3. **We always check patient's insurance, if patient's insurance has changed or benefits discontinued and PATIENT FAILS to inform the office about the changes on time, patient is responsible for the costs personally.**
   INITIAL:

MEDICAL HISTORY

1. **Name and number of physician?**

2. **When was your last medical examination?**

3. **Are you presently receiving treatment for any medical conditions?**

4. **Do you have any allergies?**

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5. **Have you ever been hospitalized for any illness or had any surgeries?**

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6. **Have you ever had an adverse reaction to any medications or injections? (including dental local anesthetic)**

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7. **Have you ever been advised to take antibiotic or premedication prior to dental treatment?**

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8. **Are you taking any medications, non-prescription drugs, or natural supplement? If yes please list them**

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9. **Do you have or have you ever had any of the following? If yes please circle**

Asthma	Heart/blood pressure problems	Hepatitis: Type: A/B/C	HIV/AIDS	Cold Sore or other viral infections	Artificial Prosthesis (heart valve or joints)
Chest Pain	Heart Attack	Stroke	Diabetes	Rheumatic Fever	Heart Murmur
Lung Disease (example: Tuberculosis)	Cancer	Chemotherapy	Arthritis	Seizure (Epilepsy)	Drugs/Alcohol
	Osteoporosis/Osteopenia	Pacemaker/Implantable Defibrillator	Mental Health Disorder	Head/Neck injuries	

Any other conditions or disease not listed above? Please describe:

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Do you smoke? If yes, how many per day?

____

FOR WOMEN:

Are you pregnant? If yes, when is the due date?

____

Are you breast feeding?

____

Signature: Date:

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