Dr. Howard Bittner Inc.

#303 6351 197th Street, Langley, BC V2Y 1X8
604-532-4090

PLEASE PRINT

Name ______________________________ Home Tel # ______________
last first initial

Address ______________________________ Work Tel # ______________
house # street city postal code

Birthdate ______________ Circle: Male / Female Spouse's Name ______________
day month year

Family Dentist ______________________________ City ______________

Family Physician ______________________________ City ______________

Parent/Guardian Name (if under 18 years): ______________________________

Relative or Friends Name & Telephone (emergency) ______________________________

Dental Insurance

Name of Policy Holder ______________________________ Birthdate ______________
Day Month Year

Employer ______________________________ S.I.N. ______________

Insurance Co. ______________

Group Policy/Plan # ______________ Cert # ______________ Dep# ______________

Relationship to policy holder ______________________________

Second Insurance Plan (if applicable)

Name of Policy Holder ______________________________ Birthdate ______________
Day Month Year

Employer ______________________________ S.I.N. ______________

Insurance Co. ______________

Group Policy/Plan # ______________ Cert # ______________ Dep # ______________

Relationship to policy holder ______________________________

OVER →

Confidential Medical History

Date of your last physical exam ____________________

Do you have a major medical problem? ☐ YES ☐ NO

If yes, please describe: ____________________

Have you been hospitalized in the past 5 years? ☐ YES ☐ NO

If yes, please describe: ____________________

Have you been in the care of a medical doctor during the past two years? ☐ YES ☐ NO

If yes, for what reason? ____________________

Have you ever had excessive bleeding following medical/dental surgery? ☐ YES ☐ NO

Do you regularly take medication or drugs of any kind? ☐ YES ☐ NO

If yes, please identify: ____________________

It's purpose: ____________________

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired? ☐ YES ☐ NO

Has your medical doctor ever said you have a cancer or tumor? ☐ YES ☐ NO

WOMEN: Are you pregnant now? ☐ YES ☐ NO

Do you have heart trouble? ☐ YES ☐ NO

Only Check Boxes that apply.

- ☐ Heart Failure
- ☐ Heart Disease
- ☐ Angina Pectoris
- ☐ Heart Attack
- ☐ Heart Valve Problems
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Congenital Heart Lesions
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse - Regurgitation

Check any of the following which you have had or have at present:

- ☐ Anemia
- ☐ Stroke
- ☐ Diabetes Type 1 / Type 2
- ☐ Epilepsy or Seizures
- ☐ Hemophilia
- ☐ Artificial Joint
- ☐ Ulcer
- ☐ Glaucoma
- ☐ Allergies or Hives
- ☐ Sinusitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Radiation Treatment
- ☐ Chemotherapy (Cancer/Leukemia)
- ☐ Colitis
- ☐ Fainting or Dizzy Spells
- ☐ Psychiatric Treatment

Diseases

- ☐ Kidney
- ☐ Liver

Allergies (Drugs):

- ☐ Penicillin
- ☐ Local Anesthetic
- ☐ Codeine
- ☐ Aspirin
- ☐ Other ____________________

Infectious Disease:

- ☐ HIV/Exposure to Aids
- ☐ Hepatitis B
- ☐ Hepatitis C

Any serious illness not listed? ____________________

To the best of my knowledge, all of the preceding answers are true and correct. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM THE DOCTOR AT THE NEXT APPOINTMENT WITHOUT FAIL.

____
Signature of Patient, Parent or Guardian

Date ____________________

____
Doctor's/Staff signature

Date ____________________