

# Patient Registration

DR. DAVID V. BRIDGER INC.

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## PERSONAL INFORMATION:

Name: \_\_\_\_\_  Miss.  Mrs.  Ms.  Mr.  Dr.  
Birthdate: (M/D/Y): \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  Single  Married  Separated  Widowed  Divorced  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_  
Phone: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_ Phone: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_  
Who will accept responsibility for payment of your account? \_\_\_\_\_  
Address: \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_  
Do you have a General Dentist?  Yes  No Name: \_\_\_\_\_

## HEALTH HISTORY

Has there been any problem in your general health within the past 5 years? (serious illness, hospitalization, surgery?)

Yes  No If so, what was the problem? \_\_\_\_\_

Are you in a high risk group for Hepatitis or AIDS?  Yes  No

Do you smoke?  Yes  No No. of Packs Per Day: \_\_\_\_\_

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING DISEASES OR PROBLEMS?:

	Yes	No		Yes	No
Rheumatic fever, rheumatic heart disease	_____	_____	Kidney troubles	_____	_____
Heart trouble, heart attack, high blood pressure or stroke	_____	_____	Diabetes	_____	_____
Radiation or treatment for a tumour or other growth	_____	_____	Psychiatric disorders	_____	_____
Blood disorders, anemia	_____	_____	Handicapped	_____	_____
Abnormal bleeding, prolonged healing	_____	_____	Asthma, hay fever	_____	_____
Fainting spells, seizures	_____	_____	Low blood pressure	_____	_____
Migraine or tension headaches	_____	_____	Artificial joint(s)	_____	_____
Hepatitis, jaundice, liver disease	_____	_____			

Any other medical condition that we should be aware of? \_\_\_\_\_

What **medications** do you take (include aspirin, etc.)? \_\_\_\_\_

Are you **allergic** to any medication? \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Address: \_\_\_\_\_

In case of emergency, please contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Women Only:** Are you pregnant?  Yes  No

(over)

