EMERGENCY PATIENT INFORMATION FORM

Do you have a fever, difficulty breathing or a cough? YES ☐ NO ☐

Have you returned from travel in the last 14 days? YES ☐ NO ☐

Have you been in contact with a suspected or confirmed case of COVID-19? YES ☐ NO ☐

Are you experiencing pain or discomfort? YES ☐ NO ☐

How did you hear about us?

PERSONAL INFORMATION

Today's Date: ____________ **Full Legal Name:** ____

Address: ____

City: ______________________________ **Postal Code:** _________________

Date of Birth: ____________ **Tel. No. (Home):** ____________________ **Tel. No. (Work):** _______________

Tel. No. (Cell): ____________ **Email Address:** ____

Preferred Pharmacy (Location): ____

MEDICAL HISTORY AND DETAILS

Have you been hospitalized or had a major operation within the last 2 years? **YES** ☐ **NO** ☐
If you indicated "Yes", please provide details:

Are you or could you be pregnant and/or breastfeeding? **YES** ☐ **No** ☐

If you indicated "Yes", please provide details: ____

Do you have, or have you ever had, a heart condition (stroke, heart murmur, surgery, pacemaker) or tested positive for a disease that could affect your immune system? (e.g. leukemia requiring chemotherapy) **YES** ☐ **NO** ☐

If you indicated "Yes", please provide details:

Please indicate which of the following you have had *or* have ever had:

- AIDS/HIV Positive YES ☐
- Alzheimer's Disease YES ☐
- Anaphylaxis YES ☐
- Anemia YES ☐
- Arthritis/Gout YES ☐
- Artificial Heart Valve/Joint YES ☐
- Asthma YES ☐
- Blood Disease YES ☐
- Cancer YES ☐
- Chest Pains YES ☐
- Circulation Problems YES ☐
- Diabetes YES ☐
- Emphysema YES ☐
- Epilepsy/Seizures YES ☐
- Eating Disorder YES ☐
- Fainting YES ☐
- Glaucoma YES ☐
- Gastrointestinal Disorders YES ☐
- Head or Neck Injuries YES ☐
- Heart Attack/Failure YES ☐
- Hepatitis A/B/or C YES ☐
- High Blood Pressure YES ☐
- Infective Endocarditis YES ☐
- Jaundice YES ☐
- Alcohol or Drug Dependency YES ☐
- Liver Disease YES ☐
- Lung Disease YES ☐
- Mental/Nervous Disorder YES ☐
- Organ/Medical Transplant YES ☐
- Sickle Cell Disease YES ☐
- Tuberculosis YES ☐

Are you currently taking any prescription or non-prescription medication? **YES** ☐ **NO** ☐

If yes, please provide details:

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CONSENT AND PAYMENT

Due to the limited number of team members at our clinic presently, we are not direct billing insurance companies for over the phone prescriptions and diagnosis. however, we are happy to continue servicing our patients by providing you with insurance forms via email, along with your payment receipt.

CREDIT CARD ____ (VISA, MASTERCARD OR AMEX)

NAME ON CARD ____

CARD NUMBER ____

EXPIRY ________/_________ CVC ______________

By signing this consent, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purpose of dental care and treatment as outlined by your clinician. You agree to the authorization of credit card transactions of the above-noted credit card in relation to dental treatment and diagnosis performed.

I have reviewed the above information and I understand that I may withdraw my consent at any time, and, should I wish to do so, I will contact the clinic to this intention. I agree that my dental clinic or dental care provider, can collect, use and disclose personal information for the purposes set out herein.

____________________________________	____
Date	**Print Name**
	____
	Signature