# Welcome To Our Office


Legal Name: William Trenker Prefer to be called: Bill

Parent/Guardian: n/a n/a

Address: 404- 1421 Sutherland Ave. City: Kelowna

Province: BC Postal Code: V1Y-8G1

Gender: Male ☑ Female ☐ Other ☐

Home #: 250 869-9949 Cell #: 250 869-9949

Date of Birth (MM/DD/YYYY): 05/31/1951

Dentist: Katie So

Did he/she refer you to our practice? Yes ☑ No ☐ Name of referral Dr. Katie So

Medical Doctor: Derek Adam

Health Care Card #: BC PHN: 9129 163 098 Email: wtrenker@gmail.com

Insurance Co # 1: (No Insurance) Insurance Co. # 2 (No Insurance)

Policy Holder_____ Policy Holder_____

Date of birth:_____ Date of birth:_____

Group/Contract:_____ Group/Contract: _____

Cert#/ID#: _____ Cert#/ID#:_____

Name of Individual Financially Responsible for Account: William Trenker

In case of an emergency, please contact: Janice Trenker 250 718-6357

**REMINDER**: Please fill out your medical history on the reverse side of this form. **OVER** ➡

# MEDICAL HISTORY

| | Yes | No |
|---|---|---|
| Have you had any previous surgeries or been diagnosed with a serious illness or disability? | ☑ | ☐ |

Specify:
Major Gastric Bleed Out / Minor Stroke / Blood Clots / others

| | | |
|---|---|---|
| Are you on any blood thinning medications? | ☑ | ☐ |

Specify: apixaban

| | | |
|---|---|---|
| Do you have any bleeding disorders? | ☐ | ☑ |

Specify:_____

Do you smoke? Yes ☐ No ☑ Nicotine ☐ Cannabis ☐ Vape ☐
If yes, how much/many per day? _____ For how long?_____
Ex-smoker? When quit? _____

Do you drink alcohol Yes ☑ No ☐ # drinks per week? 1 beer per month

Are you presently pregnant? Yes ☐ No ☑ Are you presently nursing? Yes ☐ No ☑

Do you have any allergies ? Yes ☐ No ☑ Height 5 feet 7 inc Weight 235 pounds
If so, please specify

Are you taking any prescription medications, over the counter, inhalers, vitamins or herbal supplements?
Yes ☑ No ☐
Specify: (see seperate document)

Do you have, or have you previously had any of the following?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| History of rheumatic fever | ☐ | ☑ | Lung disease or Asthma | ☐ | ☑ |
| Heart murmur | ☐ | ☑ | Sinus Infections | ☐ | ☑ |
| Heart Attack | ☐ | ☑ | H.I.V. – A.I.D.S. | ☐ | ☑ |
| Artificial heart valve | ☐ | ☑ | Diabetes | ☑ | ☐ |
| High blood pressure | ☐ | ☑ | Kidney disorders | ☐ | ☑ |
| Pacemaker implant | ☐ | ☑ | Thyroid disorders | ☑ | ☐ |
| Angina/chest pain | ☐ | ☑ | Stroke | ☑ | ☐ |
| Liver disorder/Hepatitis | ☐ | ☑ | Arthritis | ☐ | ☑ |
| Mental Health Issues | ☑ | ☐ | Epilepsy | ☐ | ☑ |
| Artificial joints/prosthesis | ☐ | ☑ | Stomach disorder | ☐ | ☑ |
| Chemo or radiotherapy | ☐ | ☑ | Sleep Apnea | ☑ | ☐ |
| Neuromuscular disorder | ☑ | ☐ | CPAP machine | ☑ | ☐ |

Other_____

Signature: _____ Date: _____