Medical Alert: _____

Lake Street Dental

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. **Please fill in the entire form.**

Personal Information	
Name: M ☐ F ☐	Occupation:
Date of Birth: (MM/DD/YY)	Whom may we thank for referring you?
Home Address:	
City: Prov: Postal:	**In case of emergency, we should notify:**
Home Phone:	Name:
Cell Phone:	Telephone:
Work Phone:	Relationship:
E-mail:	Name of Family Doctor:
Preferred contact method:	Telephone:

1. Are you being treated for any medical condition presently or have been treated within the past year? If yes, please specify:

2. When was your last medical checkup?

3. Have you ever been hospitalized for any illnesses or operations? If yes, please specify:

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please specify:

5. Do you have any allergies? (ex: medications, latex/rubber products, foods) If yes, please specify:

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please specify:

7. Do you have or have ever had a replacement or repair of a heart valve, an infection of the heart (ex: infective endocarditis), a heart condition from birth (ex: congenital heart disease) or heart transplant? If yes, please specify:

8. Do you have a prosthetic or artificial joint? If yes, please specify:

9. Have you ever been advised to take antibiotics before dental appointments? If yes, please specify:

10. Do you any conditions or therapies that could affect your immune system? (ex: leukemia, AIDS, HIV infection, radiotherapy, chemotherapy) If yes, please specify:

11. Have you ever had hepatitis, jaundice or live disease? If yes, please specify:

12. Do you have a bleeding problem or bleeding disorder? If yes, please specify:

Continued on back

13. Do you have or have ever had any of the following? Please check:

- ☐ Chest pain, angina
- ☐ Heart attack
- ☐ Stroke
- ☐ Shortness of breath
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Pacemaker
- ☐ Lung disease
- ☐ Depression
- ☐ Psychiatric problems
- ☐ Steroid therapy
- ☐ Diabetes
- ☐ Stomach ulcers
- ☐ Arthritis
- ☐ Seizures (epilepsy)
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Osteoporosis
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Asthma
- ☐ Mitral valve prolapsed
- ☐ Drug/alcohol dependency
- ☐ Cholesterol

14. Are there any conditions or diseases not listed above that you have or have had? If yes, please specify:

_____

15. Are there any diseases or medical problems that run in your family? (ex: diabetes, heart disease, cancer) If yes, please specify:

_____

16. Do you smoke or chew tobacco products? If yes, please specify:

_____

17. **For women only:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

_____

I verify that all the information which I have indicated in my medical/dental history is true and that all medical conditions have been declared on this form. I authorize the dentist/dental professionals to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by him/her to make a thorough diagnosis of my dental needs. I understand that all dental treatment and the use of anesthetic agents embody certain risks.

Signature of patient/guardian: _____ **Date:** _____

Dental History

1. When was your last dental visit? _____
2. What dental conditions/concerns do you have presently?_____
3. When did you last have dental x-rays?_____
4. How often do you brush your teeth?_____
5. How often do you floss your teeth?_____
6. What other oral aids do you routinely use? _____
7. Do you want to keep your natural teeth?_____
8. Do you have any dental appliances? (ex: dentures, implants) _____
9. Are you a mouth breather? _____
10. Are you nervous during dental treatment?_____

Financial Policy

Payment is due on or before time of service. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles my insurance does not cover. I hereby authorize payment directly to this office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize any release of information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature of patient/guardian: _____ **Date:** _____