

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.

PATIENT CONTACT INFORMATION

Mr. Mrs. Ms. Miss Dr. Other

Marital Status: Single Married/Common Law Other

First Name: _____ Last Name: _____ Preferred Name: _____

Date of Birth: ____ / ____ / ____ (MM/DD/YY) Address: _____

Apt/Unit#: _____ City: _____ Province: _____ Postal Code: _____

Employer: _____ Position: _____ Work Number: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Best way to contact you: Home Cell Work Email Best time to contact you: Morning Afternoon Evening

In case of an emergency please notify: _____ Relation: _____ Phone Number: _____

REFERRAL INFORMATION

Where have you seen us? (Please check all that apply)

Facebook Instagram Flyer Walked by Internet-Search Engine(google,etc): _____

Billboard: _____ Word of Mouth - Name: _____ Other: _____

DENTAL HISTORY

Please share the dates for the following:

Last dental visit: _____ Last dental cleaning: _____ Last dental x-rays: _____

Last oral cancer screening: _____ Do you use tobacco products: Yes No

If yes; Cigarettes Chewing Tobacco How often? _____ How long (months/years): _____

Please check any of the following that may apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Sensitivity [hot/cold/sweets] | <input type="checkbox"/> Headaches, earaches, neck pain | <input type="checkbox"/> Pain/Discomfort while chewing |
| <input type="checkbox"/> Grinding and/or clenching | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Jaw Joint Pain [clicking/cracking] |
| <input type="checkbox"/> Broken tooth or filling | <input type="checkbox"/> Bad breath/ bad taste in mouth | <input type="checkbox"/> Loose, tipped or shifting teeth |
| <input type="checkbox"/> Sore spots and/or growths | | |

Do you or have you ever had any of the following:

Dentures/Partial Dentures Orthodontic Treatment[Braces] Periodontal Treatment Difficult Extractions

DENTAL HISTORY CONTINUED

If you could change your smile, what would it be?

- White Teeth Straighter Teeth Close spaces/gaps Repair a chipped tooth Replace missing tooth/teeth
 Replace metal fillings replaced with natural colour fillings Replace old crowns Have a smile makeover

The name of your previous Dentist: _____ Why did you leave? _____

Has anything kept you from having dental treatment in the past? _____

What is most important to you about your future smile and oral health? _____

MEDICAL HISTORY

Please check all that apply to you:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Diabetes Type 1 / 2 | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Drug/Alcohol Dependency | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV+ | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> HPV | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Stomach Issues |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD | <input type="checkbox"/> Kidney Issues | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bruises Easily | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy/Radiation | <input type="checkbox"/> Heart Lesions | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Other: |

Do you have any allergies:

- Penicillin Latex Sulpha Nitrous Oxide Aspirin Local Anesthetic Codeine Erythromycin
 Other:

Have you ever had a joint replacement? Yes No If yes; when: _____

Has your physician ever told you to take antibiotics prior to dental procedures? Yes No

Have you ever experienced complications following a medical or dental procedure? Yes No Specify: _____

Are you currently under the care of a physician? Yes No Physicians Name & Number: _____

Women Patients only: Are you pregnant? Yes No Are you breastfeeding: Yes No

Are you taking any medications? Yes No If yes, please specify: _____

Is there anything else you think we should know regarding your medical history? Yes No Specify: _____

PRIVACY INFORMATION

I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me. If required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist and his/her auxiliary staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided.

Consent for Collection, Use and Disclosure of Personal Information

I agree that Lake Street Dental has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I consent and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Protection Act, 2004.

Date: _____ Signature: _____



Lake Street Dental

CANCELLATION POLICY

We pride ourselves on keeping our costs affordable for our patients. One way we do that is efficient use of equipment and professional staff. If your appointment time becomes inconvenient for you, we are always happy to change it if you provide us with a minimum two business days' notice. This allows us to schedule in a patient who may be in urgent need of care.

We strive to accommodate the scheduling needs of our patients and we will make every effort to keep your schedule on time.

Failure to provide us with 2 business days' advance notice or failure to show up for a scheduled appointment will result in a cancellation/ no show fee of \$100.00 per person.

Our goal in communicating our cancellation/no show policy is to avoid any extra charges from occurring.

We thank you for your cooperation and understanding.

Patient/Guardian Signature

Date

Witness Signature

Date