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 read and complete 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:

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

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
☐ 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:

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

Do you have any allergies:

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

What Pharmacy do you use (name and/or location)?: _____

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 achieve this is through the efficient use of equipment and our professional staff. If your appointment time becomes inconvenient for you, we are always happy to change it if you provide us with a minimum of two business days' notice. This allows us to schedule patients 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 a minimum of 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**