



TORONTO
LAKE SHORE DENTAL
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 Welcome to our dental practice!

Please be so kind as to complete this form. We thank you for your time.

(a parent, guardian or substitute decision maker will be responsible for decisions on my treatment yes no)

Name: _____

Street Address: _____

City: _____ Postal Code: _____

Date of Birth: _____ (DD/MM/YYYY)

Home phone: _____

Work phone: _____

Cell phone: _____

E-mail address: _____

Preferred method of contact? (check one):

- Home #** **Cell #** **Work #** **Email Address**

How did you hear about our practice?

- Website Referral Mailer Opencare Front Signage Others

Emergency Contact: _____

Telephone: _____

Do you have dental insurance? Yes No

If yes, please provide us with your dental insurance card.

Did you know that we have a finance program called "Health Smart" where you get instant approval for credit online? We also offer an in house payment plan for bigger treatments. Ask us for more detail.

Dental History

What is the reason for today's visit? _____

When was your last dental check up? _____

Reason for leaving last dentist? _____

Do you regularly have dental cleanings done? Yes No

Do you like your smile? Yes No

If No, please explain what you would like to change _____

Have you had a bad experience in a dental office? Yes No

If Yes, please explain _____

Medical History

Do you smoke or use tobacco in any other form? Yes No

(Women) Do you use prescribed birth control Yes No

Are you pregnant

Yes

No

Are you nursing

Yes

No

If you ever had any of the following medical conditions listed below, please check:

- | | |
|---|--|
| <input type="checkbox"/> Anemia/Radiation treatment | <input type="checkbox"/> Artificial Bones / Joints / Valves |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Cancer / Chemotherapy |
| <input type="checkbox"/> Emphysema / Glaucoma | <input type="checkbox"/> Drug / Alcohol Abuse |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Epilepsy / Seizures / Fainting Spells |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Surgery / Pacemaker |
| <input type="checkbox"/> Hemophilia / Abnormal Bleeding | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Hospitalized for any reason | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Rheumatic / Scarlet Fever | <input type="checkbox"/> Severe / Frequent Headaches |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Ulcers / Colitis |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Diabetes |

You don't have to fear dentistry anymore. We offer three different levels of sedation. Please ask us for more detail.

Please list any serious medical conditions or recent surgeries you had:

Are you taking any prescription by physician or over the counter drugs? Yes No

If yes, please list each one:

Do you require premedication? Yes No

Are you allergic to any of the following? If so please circle.

- | | | | |
|---|---------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Jewelry / Metals | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Dental Anesth | <input type="checkbox"/> Latex |

Please list any other allergies: _____

I understand that the information that I have given today is correct to the best of my knowledge and this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patients Signature

Doctor's Signature

Today's Date