LONSDALE DENTAL CENTRE

Please complete the following information in order for us to provide you with the best dental care.
All information is confidential and is for our records only.

Mrs / Ms / Miss **Last Name:** _____

Mr / Mstr / Dr **First Name:** _____ **Preferred Name:** _____

Male / Female **Date of Birth:** _____

Address: _____

City: _____ **Postal Code:** _____

Home # _____ **Cell #** _____ **Other #** _____

Email: _____ **Preferred Contact Method: Text Email Phone**

Insurance Company_____ **Policy#**_____ **ID#** _____

How did you hear about us? _____

Medical History

Name of Family Physician: _____

Women Only - Are you pregnant? Yes No Due Date: _____

Have you been ***hospitalized*** in the past 5 years? Yes / No

If yes, for what reason? _____

Do you have any ***ALLERGIES*** ? Yes / No

If yes, what are you allergic to? _____

Please circle ***CHECK*** of the conditions that you have now or in the past

Asthma /Emphysema	Low / High Blood Pressure	Epilepsy / Seizure disorder	Thyroid Disease
Hay Fever	Heart Murmur	Stomach Disorder	Blood Disorder
Diabetes	Heart Attack / Surgery	Arthritis / Rheumatism	Anemia
Sinus Troubles	Artificial: Joints / Heart Valves / Pacemaker		Lung Disease /TB
AIDS / HIV	STD (sexually transmitted disease)		Liver Disease
Substance Abuse	Frequent Alcohol Consumption		Jaundice/Hepititis
	Frequent / Severe Headaches		

If you have any other medical conditions not mentioned above, please describe: _____

Please list any medications you are taking: _____

Do you smoke? (tabacco, marijuana, other) How many per day / for how long?

(please turn over)

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Dental History

Name of previous Dentist: _____ Date of Last visit: _____

Purpose of todays visit: _____

Have you had regular dental visits in the past? Yes / No Are you in any dental pain? Yes / No

Have you been treated for periodontal (gum) disease in the past?	Yes	No
Is there a family history of peridontal (gum) disease?	Yes	No
Do your gums bleed when you brush or floss?	Yes	No
Do you have sore or lumps in your mouth?	Yes	No
Do you get any popping or clicking sounds from your jaw?	Yes	No
Are you aware of clenching or grinding your teeth?	Yes	No
Have you had surgery / radiation treatment to your neck/head?	Yes	No
Have you ever had orthodontic treatment (braces)?	Yes	No

Have you ever had a bad reaction or abnomal bleeding with past dental proceedures? Yes / No

How many time per day do you brush? _____ floss? _____

Does the appearance of your teeth concern you? Yes No

If yes, please explain: _____

When receiving dental treatment would you consider yourself: ___ Relaxed __ Mildly Apprehensive __ Nervous but under control __ Extremely Nervous

What concerns you the most about receiving dental treatment? _____

What are your current dental issues/concerns?

A friendly reminder, should you need to make a change to your appointment with us, we respectfully request 2 business days' notice to avoid a fee being applied.

Consent to Treatment:

1.) I certify that the above informations is correct to the best of my knowledge
2.) I authorize the doctor upon consultation and direct consent from the patient / parent / guardian to perform diagnostic procedures, treatment and medications in the connection of the patients dental needs
3.) I understand that the responsibility for payment of dental services, including insurance or otherwise, is due and payable at the time the services are rendered and dispite any dental insurance. I understand I am ultimately responsible for any fees withheld by the Insurance company

_____ _____ **( ) Patient( ) Parent ( ) Guardian**

Date **Signature**