LAKE LOON
FAMILY DENTISTRY

Patient Medical & Dental History

Last Name: First Name: Middle Initial:

Date of Birth: Gender: ◯ Male ◯ Female

Street Address: City/Town: Prov:

Postal Code: Home Phone: Work: Cell/Other:

Email:

Preferred method of contact: ☐ Home ☐ Work ☐ Cell/Other ☐ Email ☐ Text Message

How did you find out about our dental office? ☐ Sign ☐ Phone book ☐ Google search ☐ YellowPages Online

☐ Friend or relative Please provide a name:

In case of emergency, please notify:

Name: Phone:

Person Responsible for Account: ◯ Self ◯ Parent/Guardian ◯ Other, please specify:

Preferred method of payment: ☐ Cash ☐ Debit/Interac ☐ Visa ☐ MasterCard

Do you have Dental Insurance? ◯ No ◯ Yes If Yes, please complete your insurance information below.

Insurance Plan #1:

Subscriber: Date of Birth:

Employer: Insurance Company:

Group: SIN or Cert #: Patient ID:

Insurance Plan #2:

Subscriber: Date of Birth:

Employer: Insurance Company:

Group: SIN or Cert #: Patient ID:

Medical:

Family Physician: Phone:

Health Card # Expiry date:

Currently under the care of a physician? ◯ No ◯ Yes

When was your last medical checkup?

Has there been any change in your general health in the past year? ◯ No ◯ Yes If Yes, please explain:

Do you have any allergies to medication? ◯ No ◯ Yes Specify:

Other allergies:

Please list ALL medications you are presently taking:

Do you have OR have you had any of the following? Please check:

- ☐ Heart problems
- ☐ High blood pressure
- ☐ Shortness of breath
- ☐ Prosthetic heart valve
- ☐ Pacemaker
- ☐ Lung disease
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Arthritis
- ☐ Stomach ulcers
- ☐ GI disorder
- ☐ Osteoporosis
- ☐ Hepatitis
- ☐ Liver disease
- ☐ HIV or AIDS
- ☐ COPD
- ☐ Bleeding disorder/problem
- ☐ Diabetes
- ☐ Cancer
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Steroid therapy
- ☐ Seizure disorder
- ☐ Bisphosphonate therapy
- ☐ Eating disorder
- ☐ Artificial joint
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ Cold sores/herpes
- ☐ Drug or alcohol dependency

☐ Other Please specify:

Please provide additional information regarding problems or disorders selected above:

For Women:

Are you pregnant? ◯ No ◯ Yes If Yes, how many weeks?

Are you breast feeding? ◯ No ◯ Yes

When was your last visit to the dentist for a check up?

Please indicate the reason for your visit to our office:

Are you having any discomfort/pain/sensitivity? ◯ No ◯ Yes

Do you use tobacco products? If so, what quantity? ◯ No ◯ Yes Amount:

Do you consume alcohol? If so, what quantity? ◯ No ◯ Yes Amount:

Are you happy with your smile? ◯ No ◯ Yes!

Please explain:

Additional information or Comments:

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct to the best of my knowledge and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment provided at each visit for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures. I authorize the electronic submission of benefit claims on my behalf to my insurance carrier. I consent to having photographs taken of me for record documentation and for illustration of my treatment. I authorize that these pictures may be used for lectures or publication for educational purposes by Dr. Carol Simpson. I consent to contact by email from the dental office for dental/community related purposes. **I acknowledge that there is a fee for missed appointments or cancellations with less than 48 hours notice at the discretion of the dental office.**

Signature of patient or parent/guardian:

Print name:

Date:

Print Form Submit