WELCOME TO LONSDALE DENTAL CENTRE

Please answer the following questions to help us to better care for your dental needs. All information will be confidential and is for our records only.

DR MR MRS MS MISS Last Name_____ First Name_____
Birthdate (M/D/YR)_____ Male( ) Female( )
Address_____ City_____ PC_____
Phone HM_____WK_____CELL_____
EMAIL_____ Occupation_____
Who may we thank for referring you?_____

MEDICAL HISTORY

Name of physician_____ phone_____
Women only – are you pregnant? **Y N** due date_____
Have you been hospitalized in the past 5 years? **Y N** If yes, for what reason?_____

Have you ever had an unusual reaction/ allergy to any medication? (ie: penicillin, codeine, local anesthetic, sulpha, NSAIDs, etc)

_____

Please circle all of the conditions that you have now or have had in the past

Asthma/HayFever	High/Low Blood Pressure	Epilepsy/Seizure Disorder	Stomach Disorders	Thyroid Disease
Cancer	Heart Murmur	Substance Abuse	Psychiatric Disorders	Blood Disorders/Anaemia
Diabetes	Heart Attack/Surgery	Arthritis/Rheumatism	Lung Disease/Tuberculosis	
Sinus Trouble	Artificial Joints/Heart Valves/Pacemaker		Hepatitis/Jaundice/Liver Disease	
AIDS/HIV+	STD (Sexually Transmitted Disease)	Frequent Alcohol Consumption		Frequent/Severe Headaches

If you have any disease, condition or problem not mentioned about, please describe_____
Please list medications you are currently taking (prescription and/or non-prescription)_____
Do you smoke?(tobacco, marijuana ,other) How many per day and for how long?_____

Dental History

Name of previous dentist_____ Date of last dental visit_____ Purpose of visit_____
Have you had regular dental visits in the past? **Y N** Are you currently having any dental pain? **Y N**
Have you been treated for periodontal (gum) disease in the past? **Y N** Is there a family history of periodontal (gum) disease? **Y N**
Do your gums bleed when you brush or floss? **Y N** Are you aware of any sores or lumps in your mouth? **Y N**
Do you get popping or clicking sounds from your jaw? **Y N** Are you aware of clenching or grinding your teeth? **Y N**
Have you had surgery/radiation treatment to your head/neck? **Y N** Have you ever had orthodontic treatment (braces)? **Y N**
Have you ever had a bad reaction or abnormal bleeding with past dental procedures? **Y N**
How often do you brush your teeth? _____ floss?_____
Is there anything about the appearance of your teeth that concerns you? _____
When receiving dental treatment would you consider yourself: Relaxed___ Mildly apprehensive___ Nervous but under control___ Extremely nervous____
What concerns you most about receiving dental treatment?_____
What, if any, is/are your current dental issue(s)?_____

Consent to Treatment:

1. I certify that the above information 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 medication in the connection with the patient's dental needs.
3. I understand that responsibility for payment of dental services, including insurance or otherwise, is due and payable at the time services are rendered and despite any dental insurance. I am ultimately responsible for any fees withheld by the insurance company.

_____ _____ Patient ( ) Parent ( ) Guardian ( )
. Date Signature