Lakeview Dental

845 Anders Road #103, West Kelowna, BC, V1Z 1J9
P: 778-795-0660 | F: 778-795-0697
reception@lakeviewdentalcare.ca

Patient Information & Health History Form

Date: ____________________

Personal Information

This patient is an: Adult Child Name of Guardian (if applicable):__________________

Name:____
First Last Middle Initial(s)

Preferred Name:_________________________ Title: Dr. Mr. Mrs. Ms. Miss

D.O.B.: M____ D____ Y____ Age:____ Sex:____ Marital Status:_______ Spouse's Name:____________

Do you have any other family members who are patients at our office?____________________________

Address: ____
Number Street Unit# City Province Postal Code

Home Phone: _________________________ Business Phone: _______________________ Ext: _____

May we call you at work? Yes No

Email: ____

Preferred Method of Contact: Phone Text Email

How did you hear about us?

Word of Mouth Billboard Google Facebook Website Other

If other, please explain: ____

Whom may we thank for referring you? ____

Health History

Family Physician: _________________________________ Phone Number: _________________

Medical Specialist: ________________________________ Phone Number: _________________

Emergency Contact: _______________________________ Phone Number: ___________________
Name, Relationship

Are you currently or have you ever been treated for a medical condition? Yes No

If yes, please explain:

____

____

When was your last doctor's visit? __________________ Last physical examination?________________

Are you currently or have you recently been taking prescription or non-prescription drugs? Yes No

If yes, please list here:

____

____

Have you ever had an adverse reaction to any of the following drugs:

Antibiotics Aspirin/Advil Codeine Local anaesthetic (freezing) Other

If other, please explain: ____

Do you have any hypersensitivities or allergies? ____

Have you ever been advised by your doctor to take antibiotics **BEFORE** dental treatment? Yes No

Do you bleed excessively from a cut or bruise easily? Yes No

Do you experience shortness of breath or chest pain with mild to moderate physical activity (e.g., walking up stairs)? Yes No

Have you ever tested positive for or come into contact with the HIV or Hepatitis viruses? Yes No

Do you suffer from frequent/severe headaches? Yes No

Have you every had an injury or surgery to your face or jaws? Yes No

Have you ever received radiation therapy or chemotherapy? Yes No

Do you smoke or use any other forms of tobacco or marijuana? Yes No

Do you use recreational drugs? Yes No

Please indicate any conditions (below) that you currently have (or ever had):

	Yes	No		Yes	No		Yes	No
Anemia			Heart disease/attack			Organ transplant		
Angina pectoris			Heart murmur			Psychiatric treatment (e.g., depression)		
Arthritis/rheumatism			Heart pacemaker			Radiation treatment/chemotherapy		
Artificial heart valve			Heart rhythm disorder			Rheumatic/scarlet fever		
Artificial joints (e.g., hip, knee)			Heart surgery			Sinus trouble		
Blood disorders			Hepatitis (A/B/C/D/E)			Stroke		
Cancer			HIV/AIDS			Thyroid disease		
Circulation Problems			High/low blood pressure			Tuberculosis		
Congenital heart defects			Hodgkin's disease			Ulcers		
Cortisone/steroids			Hypertension			Asthma		
Diabetes			Jaundice/Liver disease			Hormone Therapy		
Emphysema			Kidney disease			Adrenal issues		
Epilepsy/seizures			Lung disease			Other		
Fainting/dizziness			Malignant hyperthermia			Other		
Head/neck injuries			Mitral valve prolapse			Other		

If needed, please explain any of the above here:

____

____

Do you currently have (or ever had) any condition not listed above? ______________________________

Is there anything else about your health we should be made aware of? ___________________________

Do you wish to speak to the doctor privately about any problem or medical condition? _____________

Women Only:

Are you pregnant, think you may be pregnant, or trying to conceive? _____________________________

If yes, when is the expected delivery date? ____________________________

Are you taking birth control pills or using any hormone-based contraceptive?______________________

Dental History

Is there a dental problem that you would like treated immediately? Yes No

If yes, please explain: ____

Do you have any other dental concerns at this time? ____

Is this your first visit to a dentist? Yes No

If no, when was your last dental visit and x-rays? _______________ Last dental cleaning?___________

*If x-rays less than 3 years ago, please complete authorization form (last page)

Have you every had any of the following:

Gum treatment: Yes No

Braces/Invisalign: Yes No

Night guard/bruxism appliance: Yes No

Wisdom teeth removal: Yes No

How often do you brush your teeth? _______________ How often do you floss? _______________

Do your gums bleed when brushing/flossing? _______________________

Are any of your teeth sensitive to the following: Hot Cold Biting Sweets

Are you missing any teeth? Yes No

If so, have they been replaced? Yes No If not, do you want them replaced? Yes No

Dental Insurance Information

Insurance Company: Plan #: Group #:

Additional Notes

Office Policies

Appointments

Please help us maintain the integrity and ongoing standard of care that our office provides to all of our patients. Remember that once you have made an appointment, this time is reserved for you; therefore, at least **TWO BUSINESS DAYS NOTICE** must be given if cancellation is absolutely necessary, otherwise a cancellation fee of $100 may apply. If you fail to show up for an appointment or cancel an appointment with less than two business days notice on two or more occasions, you may be dismissed as a patient from our office.

Payment of Fees

1. This office accepts most dental insurance plans. We are willing to accept direct payment from your dental plan for services which your plan covers.
2. If your dental plan does not cover the full cost of your treatment, you will be responsible for any difference between the amount paid by your plan and the amount charged.
3. Your portion is then due and payable on the day of your appointment unless other financial arrangements with our office have been made.

Personal Information & Additional Parties

I authorize release to Lakeview Dental information contained in pre-authorization and claims submitted electronically and otherwise. I also authorize release of information pertaining to my dental coverage and benefits as well as personal information to Lakeview Dental's financing partners if I choose to apply for financing.

Contact

I authorize Lakeview Dental to contact me through phone, email, text, or any other means of communication agreed upon. If I cannot be reached by my preferred method of contact, Lakeview Dental may try the other methods of contact that I have provided.

General Release

I, the undersigned, certify that I have provided an accurate and complete personal, medical, and dental history and have not knowingly omitted information.

Patient Signature: ____ Date: _____________________

Parent/Guardian Signature: ____________________________ Relationship to patient: _____________
(if applicable)

Smile Questionnaire

Today's Date: ____________________

Patient Name: ____________________

Date of Birth: ____________________

Reason for today's visit: ____________________

1. How important do you consider your oral health?
   Not important   somewhat important   very important

2. Which of the following oral health conditions have you experienced since your last dental exam? Please check all that apply.
   - ❏ Tooth ache
   - ❏ Loose, chipped, cracked or broken fillings
   - ❏ Grinding teeth
   - ❏ Clicking or popping jaw
   - ❏ Clenching jaw
   - ❏ Headaches
   - ❏ Snoring or sleep apnea
   - ❏ Sensitivity to hot, cold, or sweet foods
   - ❏ Red, puffy, or tender gums
   - ❏ Teeth have moved

3. On a scale from 1-10, how confident are you in your smile? Please circle your answer.

   1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10

4. If you could change your smile, would you:
   - ❏ Make your teeth whiter?
   - ❏ Close gaps between your teeth?
   - ❏ Make your teeth straighter?
   - ❏ Fix chipped or cracked teeth?
   - ❏ Replace missing teeth?
   - ❏ Other

5. Have you had your teeth straightened in the past? (Braces, clear aligners, or other appliances)
   - ❏ Yes (date: MM/DD/YY to MM/DD/YY)
   - ❏ No

6. When deciding to start dental treatment, rank these factors from most important to least important.
   - ❏ Comfort
   - ❏ Length of treatment
   - ❏ Price
   - ❏ Insurance coverage
   - ❏ Appearance/Aesthetics
   - ❏ Frequency of check-in appointments
   - ❏ Other (please specify):

7. When would you like to share your new smile with the world?
   - ❏ As soon as possible
   - ❏ Wedding (date: MM/DD/YY)
   - ❏ Birthday
   - ❏ Vacation
   - ❏ Reunion
   - ❏ Other

8. Is there anything else you'd like us to know?

SureSmile® | Dentsply Sirona

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Authorization for Release of Dental Records & X-Rays

Date: ____________________

I, (print patient name) ____, hereby authorize the doctor(s) and staff of (print previous dental practice name) _____________________________________ to release my dental records, x-rays (including bitewings, PAs, panoramic, CBCT, or any other type of radiograph taken within the past three years), and any information pertinent to my ongoing oral healthcare to:

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* If sending digital records/x-rays, please send by email to **reception@lakeviewdentalcare.ca.**
***** Please include dates of x-rays.

Sincerely,

______________________________ ________________________

Signature of patient Date

____

Signature of parent/guardian (if applicable)