

Health History

Family Physician: _____

Phone Number: _____

Medical Specialist: _____

Phone Number: _____

Emergency Contact: _____

Name, Relationship

Phone Number: _____

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#:

Name and birthday of plan member (if it belongs to your spouse/partner):

Insurance Company:

Plan#:

Group#:

Name and birthday of plan member (if secondary insurance):

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 \$200 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. **Please note that this is a courtesy we provide. It is still up to you, as a patient, to understand what your plan does and does not cover.**
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)



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

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:

Lakeview Dental

845 Anders Road #103, West Kelowna, BC, V1Z 1J9

reception@lakeviewdentalcare.ca

- * 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)