Lakeside Dental
#7 - 4800 Island Hwy. North
Nanaimo BC V9T1W6

www.lakesidedentalclinic.ca
(250)756-1300
lakesidedental@telus.net

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #.

FOR OFFICE USE ONLY

Patient Name:

Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: Prev. Visit: Email Address:

Phone: Best time to call:

Home Work Ext Mobile

Address:

City PV Postal Code

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

- ☐ Yellow Pages
- ☐ MOBILE Yellow Pages
- ☐ Coupon Code_____
- ☐ Public Lecture
- ☐ Facebook
- ☐ Tradeshow _____
- ☐ TV
- ☐ Friend Coworker or Family Member _____
- ☐ GOOGLE
- ☐ Internet
- ☐ Highway Sign
- ☐ Location
- ☐ Newspaper (Ask an Expert)
- ☐ Radio

Response Date:

Lakeside Dental
#7 - 4800 Island Hwy. North
Nanaimo BC V9T1W6
(250)756-1300
www.lakesidedentalclinic.ca
lakesidedental@telus.net

Medical & Dental History Form

Your Primary Care Physician's name and location:

Please mark any of the following to indicate Yes in response to the question:

- [ ] Are you currently under the care of a physician due to a specific condition?
- [ ] Have you been hospitalized within the last 5 years due to a surgery or illness?
- [ ] Do you heal abnormally or slowly?
- [ ] Do you use tobacco (smoking or chewing)?
- [ ] Have you ever had complications following dental treatment?

If any of the previous questions are marked, please explain:

Are you currently taking any prescription or non-prescription medication?

◯ Yes ◯ No

Please list these medications below:

WOMEN: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

Please indicate if you have exprienced any of the following:

◯ Pre- Med Antibiotic	◯ Bisphosphonates	◯ Pacemaker
◯ Ulcers	◯ Diabetes	◯ Sinus Problems
◯ Hepatitis	◯ Allergies	◯ Asthma
◯ Blood Thinners	◯ Drug Dependency	◯ HIV + (AIDS)
◯ Osteoporosis/Bone Disease	◯ Cancer	◯ Heart Attack
◯ Heart Surgery/Stent	◯ Stroke	◯ Kidney/Liver Disease

Please expand on any of the previous medical conditions that affect you or any other health issues or allergies not listed above?

What is the reason for your dental visit today?

When was your last visit to the dentist? Prior Dentist's name and location.

Please mark any of the following to indicate Yes in response to the question:

- [ ] Do you ever clench or grind your teeth?
- [ ] Do your gums bleed when you brush or floss?
- [ ] Are any of your teeth sensitive?
- [ ] Are you interested in implants to replace missing teeth?
- [ ] Are you interested in alternatives to "silver mercury" fillings?
- [ ] Would you like your teeth to be whiter?
- [ ] Are you concerned about pain during treatment?
- [ ] Are you a nervous dental patient?

Would you be interested in having straight teeth by the time of your next cleaning appointment?

◯ Yes ◯ No

Should you qualify, would you be interested in a free cosmetic simulation to see what your teeth would look like whiter or straighter?

◯ Yes ◯ No

What bothers you most about having dentistry done?

If you could change anything about your mouth, teeth, or smile, what would it be?

- [ ] To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health

Lakeside Dental
#7 - 4800 Island Hwy. North
Nanaimo BC V9T1W6
(250)756-1300
www.lakesidedentalclinic.ca
lakesidedental@telus.net

Sleep Apnea Screening

Do you snore loudly? (Louder than talking, or loud enough to be heard through a closed door?

◯ Yes ◯ No

Do you often feel tired, fatigued, or sleepy during the day?

◯ Yes ◯ No

Has anyone observed you stop breathing during your sleep, or have you been jolted awake gasping for breath?

◯ Yes ◯ No

Do you have, or are you being treated for high blood pressure?

◯ Yes ◯ No

Are you overweight, or do you have a neck size greater than 17 inches?

◯ Yes ◯ No

Have you ever been tested and/or treated for Sleep Apnea?

◯ Yes ◯ No

If any of the previous questions are marked, please explain:

Response Date:

Lakeside Dental
#7 - 4800 Island Hwy. North
Nanaimo BC V9T1W6

www.lakesidedentalclinic.ca
(250)756-1300
lakesidedental@telus.net

Authorization

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I authorize the use of photographs of my teeth for lectures and educational purposes as long as my identity is not revealed.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____