Lakeshore **W**est **D**ental

3390 Lake Shore Blvd., W. Office: 416-251-5707
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PATIENTS NAME ______________________________ **DATE** ______________

DATE OF BIRTH __________ **SEX**______**WEIGHT**______**REFFERRED BY**________________

ADDRESS ______________________________ **CITY**__________ **POST.CODE**__________

HOME# ______________ **WORK #**________________ **CELL#** ________________

EMAIL ADDRESS____

(I agree to receive communications via email for appointment notifications, treatment and care instructions etc…)

DRIVER LICENSE______________________________ **SIN**________________

FAMILY MEDICAL Dr. __________________________ **PHONE:** ________________

MEDICAL HISTORY. Please circle, if you now have or ever have had any of the following.

A.I.D.S	Glaucoma	Mental/nervous disorder
Anemia	Head/neck injuries	Mitral valve prolapse
Angina pectoris	Heart disease or attack	Organ transplant/medical implant
Arthritis/rheumatism	Heart murmur	Psychiatric treatment
Artificial heart valve	Heart pacemaker	Radiation treatment/chemotherapy
Artificial joints (hip, knee)	Heart rhythm disorder	Scarlet fever / Rheumatic fever
Blood disorders	Heart surgery	Sickle cell disease
Bronchitis	Hepatitis A B C	Sinus trouble
Cancer	Herpes	Stomach/intestinal problems/ulcers
Circulation problems	High/Low blood pressure	Stroke
Congenital heart lesions	Hodgkins disease	Thyroid disease
Cortisone/steroid	Inflammatory bowel disease	Tuberculosis
Crohn's disease	Jaundice	Venereal Disease
Diabetes	Kidney disease	Other ________________
Emphysema	Liver disease	Other________________
Epilepsy or seizures	Lung disease	Other ________________
Fainting or dizzy spells	Lupus	Other________________
Glandular disorders	Malignant Hyperthermia	Other________________

NONE OF THE ABOVE ☐

Please circle YES or NO to the following questions. If YES please specify.

*Have you ever had any injury or surgery to your face or jaws?	NO	YES
****Are you allergic or sensitive to any medicines or anything used in the dental office such as latex or metal?***	NO	YES
*Have you been hospitalized in the last 10 years?	NO	YES
*Are you taking any medicines now? Please list Medications	NO	YES

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*Do you wear contact lenses?	NO	YES
*Do you smoke?	NO	YES
*Have you had any previous surgery?	NO	YES
*Have you ever had an unusual reaction to local or general anaesthesia?	NO	YES
*For Females; Are you pregnant or suspect you could be pregnant?	NO	YES

To the best of my knowledge the above information is correct.

______________________________ ______________________

Patient/parent guardian signature Date