200-215 JOSEPH OKEMASIS DRIVE
SASKATOON, SK S7N 3A8
PH: (306)986-5323 FAX: (306)986-5324
reception@lakesidedentalsaskatoon.ca

@Lakesidedentalsaskatoon
Lakeside Dental Saskatoon

General Information

Legal name: _____
Preferred name: _____
Middle name: _____
Last name: _____
Health card #: _____

Contact information

Cell #: _____
Home #: _____
Work #: _____
Address: _____
Postal Code_____

Emergency contact: _____
Relationship: _____
Phone #: _____

Employer name: _____
Occupation: _____
Phone #: _____

Family Doctor Name: _____
Address: _____
Phone #: _____

Pharmacy name: _____
Address: _____
Phone #: _____

Date of birth: _____
Sex: _____Pronouns(*optional*)_____
Email address: _____
How did you hear about us? _____

Primary Insurance Information

Insurance Carrier Name : _____

Employer Name: _____

Subscriber Name and D.O.B:

_____
Group #: _____
ID #: _____

Secondary Insurance Information

Insurance Carrier Name : _____

Employer Name: _____

Subscriber Name and D.O.B:

_____
Group #: _____
ID #: _____

Dental Information: **CHECK ALL THAT APPLY**

Do your gums bleed when you brush or floss? ☐ YES ☐ NO

Are your teeth sensitive to hot/cold/pressure, or sweets? ☐ YES ☐ NO

Does food or floss catch between your teeth? ☐ YES ☐ NO

Have you had any periodontal (gum)treatment? ☐ YES ☐ NO

Have you ever had orthodontic(braces)treatment? ☐ YES ☐ NO

Do you wear dentures? ☐ YES ☐ NO

Do you grind your teeth? ☐ YES ☐ NO

Do you have any sores or ulcers in your mouth? ☐ YES ☐ NO

Have you had a serious injury to your head, neck, or mouth? ☐ YES ☐ NO

Are you currently experiencing dental pain or discomfort? ☐YES ☐ NO

Do you have earaches or neck pains? ☐ YES ☐ NO

Do you have any clicking, popping, or discomfort in your jaw? ☐ YES ☐ NO

Do you have severe issues with coughing? ☐ YES ☐ NO

Do you drink alcoholic beverages? ☐ YES ☐ NO If *yes, how often?* _____

Do you use tobacco products? ☐ YES ☐ NO If *yes, how often?* _____

Do you use other substances? ☐ YES ☐ NO If *yes, how often?* _____

Do you use a vape? ☐ YES ☐ NO If *yes, how often?* _____

Do you have sleep apnea? ☐ YES ☐ NO

Are you taking any over the counter medications or prescribed medications? ☐ YES ☐ NO

*If yes, please list them here*_____

Have you had a serious reaction to local anesthetic? ☐ YES ☐ NO

Have you had a serious illness, operation, or have been hospitalized in the past 5 years? ☐ YES ☐ NO

Have you had an orthopedic total joint replacement? ☐ YES ☐ NO *If yes, when?* _____

Has there been any change to your general health within the past year? ☐ YES ☐ NO
If yes, please explain: _____

Has a physician or a previous dentist recommended that you take antibiotics prior to your dental treatment?

☐ YES ☐ NO

Is there anything about your smile that you would like to change? ☐ YES ☐ NO

Are you taking a hormone replacement? ☐ YES ☐NO

Are you pregnant? ☐ YES ☐ NO *If yes, are you nursing?* ☐ YES ☐ NO Are you taking birth control? ☐ YES ☐ NO

When was your last physical exam? _____

Medical Information

Allergies*: please circle yes or no*

Y / N Latex
Y / N Penicillin
Y / N Sulfa
Y / N Acrylic
Y / N Hay fever/seasonal
Y / N Local Anesthetic
Y / N Animals

Y / N Aspirin
Y / N Fluoride
Y / N Iodine
Y / N Morphine
Y / N Metals
Y / N Ibuprofen/Motrin/Advil
Y/ N Codeine
Other_____

Conditions: *please circle yes or no*

Y / N Abnormal/excessive bleeding
Y / N Angina
Y / N Asthma
Y / N Blood transfusion
Y / N Cardiovascular disease
Y / N Damaged heart valves
Y / N Epilepsy
Y / N Heartburn
Y / N Heart murmur
Y / N Heart attack
Y / N Hepatitis, jaundice, or liver disease
Y / N Low pain tolerance
Y / N Persistent swollen glands in neck
Y / N Rheumatic heart disease
Y / N Sexually transmitted infection
Y / N Stroke
Y / N Thyroid problems
Y / N Ulcers
Y / N TMJ disorder
Y / N AIDS/HIV
Y / N Anxiety
Y / N Autoimmune disease
Y / N Respiratory problems
Y / N Chest pain

Y / N Diabetes
Y / N Glaucoma

Y / N High Blood Pressure
Y / N Malnutrition
Y / N Osteoporosis
Y / N Psychiatric care
Y / N Sinus trouble
Y / N Alzheimer's/dementia
Y / N Arteriosclerosis
Y / N Bronchitis
Y / N Eating disorder
Y / N Gout
Y / N Kidney problems
Y / N Recurrent infections
Y / N Tuberculosis
Y / N Anemia
Y / N Arthritis
Y / N Blood disease
Y / N Cancer/chemo/radiation treatment
Y / N Emphysema
Y / N Gastrointestinal disease
Y / N Hearing difficulties
Y / N Hemophilia
Y / N Low blood pressure
Y / N Neurological disorders
Y / N Pacemaker

Y / N Rheumatic fever
Y / N Severe or rapid weight loss/gain
Other _____

Patient Agreement

I agree that the information provided in this form is accurate and true. A truthful health history will help ensure the best possible dental treatment. The information provided will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below, you acknowledge that you will not hold the dentist, the dental practice, or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

I also acknowledge that Lakeside Dental is a third-party associate to insurance and offers direct billing as a courtesy. Should there be errors, discrepancies, or unpaid claims, it is my obligation to pay the dental practice and follow up with my insurance.

Furthermore, I understand that Lakeside Dental requires 48 hours' notice to make any appointment changes. I agree to provide two business days' notice in the event I need to reschedule my appointment; failure to do so will result in a $50.00 short notice fee and/or a deposit to reschedule.

Signature: _____Date: _____