BY THE LAKE DENTAL®
Efficient and effective dental care

Dr. Patricia Khamis-Silva
Dr. Afson Ferdosmakan
Dr. Gloriana Ramirez
Dr. Steve Ma
Dr. Kirill Khromov
Dr. Mona Kamur
Dr. Pooneh Mohebbi
Dr. Taras Klitovchenko

MEDICAL HISTORY

Your health information is essential to our ability to efficiently and effectively treat your dental requirements. Please complete this information accurately. All personal information is strictly confidential and used exclusively by, By the Lake Dental. **PLEASE PRINT CLEARLY.**

Patient Name: _____

Family Doctor: _____ **Phone Number:** _____

Are you being treated for any medical conditions at the present time? **Yes** | **No** **Details:** _____

Please check if you have had or have any of the following conditions:

☐Allergies (Please list): _____			☐Pregnant (months)
☐Anemia	☐Emphysema	☐Hepatitis ☐A ☐B ☐C	Prosthetic: ☐limb ☐organ
☐Arthritis	☐Epilepsy	☐High blood pressure	☐ Rheumatic Fever
☐Asthma	☐Heart attack	☐HIV related issues	☐ Sleep Apnea
☐Bleeding	☐Heart condition	☐Kidney issues	☐ Stomach issues
☐Cancer (Please list): _____			☐ Stroke
☐Chronic bronchitis	☐Heart Murmur	☐Liver issues	☐ Thyroid disease
☐Diabetes	☐Heart valve surgery	☐Osteoporosis	☐ Tuberculosis
☐Smoker	How Long? _____	Frequency of use: _____	
☐Cannabis	How Long? _____	☐Medicinal ☐Recreational	Frequency of use: _____
Other conditions: _____			

Please list any current medication, including over the counter (if you need additional space, please write on the back of this page

_____

DENTAL HISTORY

My most recent dental visit: _____ I see my dentist every: 3 months / 6 months / 12 months / Not routinely
Have you ever had local anesthetic? (Freezing) Yes / No were there any complications? Yes/ No
Have you ever had Botox treatment before? Yes / No If yes, what was the reason? *Cosmetic / Therapeutic*

Please circle if any of the following apply to you:

Bleeding Gums	Unpleasant Taste/ Bad Breath	Frequent Blisters	Swelling/ Lumps in mouth	Ortho Treatment
Difficulty Chewing	Teeth Sensitivity Hot/ Cold	Clicking/ Popping jaw	Clenching Grinding/TMJ	Headaches

I understand the above information is necessary to provide me with dental care in a safe, efficient and effective manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my consent to ask the respective health care provider to release such information. I will notify the dentist of any change to my health or medication.

Print Name	**Relationship to Patient**	**Signature**	**Date**