# LG Dental Centre
# Dr. Larry Goldstein B.A. D.D.S

**PERSONAL INFORMATION (please print)**

**Patient Name**________________________________________________________
(Last) (First) (Mr/Mrs/Miss/Ms/Dr)

**Address**____________________________________________________________
Street name & # Apt # City Postal Code

**Telephone: (H)** ______________________ **Birth Date:** ________________________

**(B)** ________________ext____ **Email** ___________________________

**Spouse's Name:**______________ **D.O.B.**_______

**WHOM MAY WE THANK FOR REFERING YOU**___________________________

**In case of emergency, contact**_________________**Tel:**________________**Relationship**__________________

****Please Note****
**For your convience we will bill your insurance company directly, however your plan is subject to change without notice therefore we cannot be held responsible for any treatment not covered.**

| **Primary Coverage** | **Secondary Insurance** |
|---|---|
| Employee Name:__________________ | Employee Name:__________________ |
| Company Name:___________________ | Company Name:__________________ |
| Insurance Company:________________ | Insurance Company:______________ |
| Group or Policy#____________________ | Group or Policy#________________ |
| Certificate #_________________________ | Certificate # _____________________ |

## Medical History Form

Please check if you now have or have had any of the following

| | | |
|---|---|---|
| □ **Chest Pain** | □**Asthma** | □**Liver Trouble** |
| □**Heart Attack** | □**Joint Replacement** | □**Hay fever/allergies** |
| □**Difficulty breathing** | □ **Kidney Trouble** | □**Cancer** |
| □**Stroke** | □**Lung Trouble** | □**Ulcers** |
| □**Prosthetic Valve** | □**Tuberculosis (TB)** | □**Diabetes** |
| □**Heart Murmur** | □**Bronchitis** | □**Seizures/Epilepsy** |
| □**Mitral Valve Prolapse** | □**Pneumonia** | □**Arthritis** |
| □**Cardiac pacemaker** | □**Rheumatic fever** | □**Thyroid problems** |
| □**Low Blood pressure** | □**Chronic fatigue** | □**Tumor** |
| □**High Blood pressure** | □**Hearing problems** | □**Head injury** |
| □**Arteriosclerosis** | □**HIV (or related)** | □**Sinus Problems** |
| □**Anemia** | □**Hepatitis** | □**Nervous Disorder** |

## MEDICAL

WHAT IS THE DATE OF YOUR LAST PHYSICAL EXAMINATION:________________________________
NAME OF YOUR FAMILY DOCTOR: ________________________________________________________

Do you smoke? **How much?**_____________________________
Are you currently taking any Prescription medications? Please List_________________________________
Are you **allergic** or sensitive to medication or **latex?**____________________
Do you use aspirin or blood thinners?_________________________________
For women: Are you pregnant?______________________________________
Are you under the care of a physician? For what?________________________

## DENTAL

NAME OF PREVIOUS DENTIST: _______________________________________________________
DATE OF YOUR LAST DENTAL APPOINTMENT:_________________________________________
DATE OF YOUR LAST DENTAL X-RAYS: _______________________________________________

□ Yes □ No Do your gums bleed with brushing or flossing?
□ Yes □ No Do you hear popping, clicking noises or have pain when you chew?
□ Yes □ No Have you ever experienced problems during dental treatment?
□ Yes □ No Do you have any concerns regarding the appearance of your teeth?

**Is there anything missed on this form you feel we should know?** ____________________________

I hereby authorize Dr. Goldstein to perform necessary treatment including emergency treatment, recall maintenance, periodontics, endodontics, oral surgery, fixed/removable prosthodontics. I consent to the administration of local anaesthesia as well as any pertinent radiographs necessary. I have had explained to me, by Dr. Goldstein, the purpose and benefits of the procedures recommended for my dental treatment. I certify that no guarantee has been made or assurance given to the results that may be obtained.

**Patients Signature**__________________________ **Date**_________________________________
**Reviewed by:**_______________________________ **Date**_________________________________