Active Westlake Dental Patient Update

Name: _____ Sex(circle): MALE / FEMALE Birth Date: _____
Cell #_____ House #_____EMAIL_____
Address:_____City_____PostalCode_____
Family Doctor: _____ Phone# _____Date of last medical_____
Have you been under a doctor's care in the last two years? **Y N** For: _____
Have you been hospitalized in the last two years? **Y N** For: _____
Have you ever had any major surgeries? **Y N** For: _____
If female: Are you taking hormones or birth control? **Y N** Are you pregnant or nursing? **Y N**
Have you ever had blood tests for hepatitis? **Y N** Were you vaccinated for hepatitis? **Y N**
Have you had canker or cold sores on your lips, in your mouth, or on your body? **Y N**
Are you now taking or have you taken any prescription drugs in the last year? **Y N** If Yes, list below
_____
Are you allergic to: **penicillin latex codeine local anesthetic none other**: _____
Have you been advised by your physician to take premedication prior to any dental treatment? **Y N**
If yes, for what condition? _____

Have you had or do you have any of the following:

Blood, Heart and Circulatory Disorders	**YES**	**NO**
Anemia	O	O
Hemophilia	O	O
Bleed easily	O	O
Blood Transfusions	O	O
Heart disease	O	O
Artificial Heart Valve	O	O
Congenital Heart Defects	O	O
Rheumatic Heart Disorder	O	O
Heart Murmur	O	O
Angina, Heart Attack, Chest pain	O	O
High Blood Pressure	O	O
Stroke or Blood Clots	O	O
Respiratory Disorders		
Lung Disease	O	O
Tuberculosis	O	O
Emphysema	O	O
Asthma or hay fever	O	O
Pneumonia or Pleurisy	O	O
Sinus trouble	O	O
Miscellaneous		
Pins, plates, replacement joints	O	O
Organ transplant	O	O
Pacemaker	O	O
Smoker	O	O

Debilitating, Infectious Disorders	**YES**	**NO**
Cancer	O	O
Chemotherapy	O	O
Radiation Therapy	O	O
Hepatitis, Jaundice	O	O
Drug, Alcohol Dependency	O	O
Mental Illness	O	O
HIV	O	O
Other Disorders		
Malignant Hypothermia	O	O
Thyroid, Adrenal disease	O	O
Diabetes	O	O
Kidney Disease	O	O
STD	O	O
Rheumatoid Arthritis	O	O
Skin rash, hives, skin disorder	O	O
Stomach or bowel disorder	O	O
Ear disorder/dizziness	O	O
Eye disorder	O	O
Epilepsy or seizures	O	O
Fainting spells	O	O

Any condition not listed?

_____

Note: *We require a minimum of 2 days notice prior to cancelling or rebooking an appointment. This gives other patients a chance to fill your time. We do not take cheques for payment.*

I understand that by signing this form I give Westlake Dental consent to send my insurance claims on my behalf and that it is my responsibility to know the coverage for my insurance policy and dates for my benefit year as there is NO DIRECT BILLING.

Signature of Patient/guardian if under 18

_____Date:_____

Please see other side →

Westlake Dental

Privacy, Disclosure, & Consent

To: Westlake Dental and Westlake Health Services

Information for our Patients

At Westlake Dental, all professional services are performed by licensed members of the ("Dental Professionals"), and all institutional services are performed independently by Westlake Health Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Westlake Dental and Westlake Health Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in Westlake Health Services.

Privacy Act and Consent to Treatment

By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code; (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code; and (iv) your previously signed consent and acknowledgment documents are extended in favour of Westlake Dental and Westlake Health Services.

You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of Westlake Dental to provide the services you are requesting.

Thank you and please do not hesitate to let us know if you have any questions regarding this form or your Personal Information.

_____ _____ _____

Print Name of Patient Signature of ☐ Patient ☐ Parent/Guardian Date

_____

Dependent Family Members

_____ _____

Reviewed by Westlake Dental Date