

## 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?**

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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

