Westlake Dental

Hours of Operation are Monday to Thursday 8am to 4pm, Friday 8am to 1pm

Our office requires a minimum of 24 hours notice prior to cancelling or rescheduling appointments or a $50 fee may apply. Please be advised we do not direct bill or accept cheques. We do take cash, debit or any credit card. Unpaid bills will be charged a 24% interest rate and will be forwarded to a collection agency.

Patient Name: ____

Phone #:______________________ Work#:___________________ Cell#:__________________________

Birth Date: ___________________________ E-Mail Address: ____________________________________

Address________________________City__________________________Postal Code________________

Spouse/Parent Name__________________________ Phone #________________________________

Next of Kin__________________________________ Phone #________________________________

Insurance Company: _________________________Group/Plan #_________Certificate/ID #_____________

Name of Insured for **Primary** Plan: _________________________________ Birthdate: _______________

Secondary Insurance: ______________________ Group/Plan #:_________Certificate/ID #: _____________

Name of Insured for **Secondary** Plan: _________________________________ Birthdate: _______________

How did you hear about us?? Google Facebook TV Radio Newspaper Yellow pages

Friend/Family _________________________

Medical Health

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? ____

Medical History

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		
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? ________________________

Dental Health

When was your last check up?_____________________.

When was your last cleaning? _____________________.

How often do you see the dentist?_________________.

Are you having any trouble now? __________________.

Do any of the following cause tooth discomfort?

Sweets__ Hot__ Cold__ Chewing__

How often do you brush a day?_____________________.

Do you grind or clench?	**Y/ N**
Do you get frequent headaches?	**Y /N**
Do you get frequent earaches?	**Y /N**
Do you chew on both sides and comfortably?	**Y /N**
Have you ever had orthodontic treatment	**Y /N**
Have you considered straightening, bleaching, crowns or veneers?	**Y /N**
Do you have spaces you would like closed?	**Y /N**

Rate your Smile :

1 2 3 4 5 6 7 8 9 10

Please add anything you feel is important we should know.

I understand that your office requires me to give a full 24 hours notice prior to cancelling or rescheduling my appointments, and that if I fail to do so, a $50 fee may apply. I understand that it is my responsibility to know the coverage for my insurance policy and dates for my benefit year.

Signature of Patient (*Guardian if under 18*)

________________________________Date:___________