Westlake Dental

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

Our office requires a minimum of *2 Days 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: _____ Sex (circle) MALE / FEMALE

Birth Date: _____ **E-Mail Address**: _____

Cell#:_____ Home Phone #:_____ Work#:_____

Address_____City_____Postal Code_____

Spouse/Parent/Next of Kin Name_____ 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 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? _____

NEXT PAGE----------→

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 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.

I understand that your office requires me to give a full 2 DAYS notice prior to cancelling or rescheduling my appointments, and that if I fail to do so, a $50 fee may apply.

How will you be paying today? (Circle please)

CASH DEBIT MASTERCARD VISA AMERICAN E

Signature of Patient (*Guardian if under 18*)

_____Date:_____

Westlake Dental

Privacy, Disclosure, & Consent

To: Westlake Dental and Westlake Health Services

Information for our Patients

At Westlake Dental, all professionals 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 for Westlake Dental; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. 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.

Acknowledgement regarding Information Provided

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical - dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to preform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provided may be necessary and I authorize the exchange of my personal information among Westlake Dental, Westlake Health Services, my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by Westlake Dental and in accordance with their current practices, which may involve transfer and retention outside of Canada. I, the undersigned, acknowledge that the Westlake Dental and Westlake Health Services are relying upon the information which I have provided being accurate and complete.

_____ _____ _____

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

_____

Dependent, Family Members

_____ _____

Reviewed by Westlake Dental Date