INTERLAKE
DENTAL CENTRE

Welcome to Interlake Dental Centre!

Confidential Patient Registration and Health History

PATIENT INFORMATION

Name Last _____ First _____ Middle Initial _____

Person Responsible for Account: Name Last _____ First _____ Middle Initial _____

Address _____

City _____ Postal Code _____

Sex M _____ F _____ Birthdate Day _____ Month _____ Year _____

Home Ph. _____ Business Ph. _____

Cell Ph. _____ E-mail _____

Preferred Contact Method (please number in sequence): Home Ph. _____ Business Ph. _____ Cell Ph. _____ E-mail. _____

Employer/School _____

How did you hear about us? _____

In case of an emergency who should be notified? _____ Their Ph. _____

DENTAL INSURANCE INFORMATION

Primary

Subscriber Name _____ Relationship to Patient _____ Birthdate _____

Address (if different from patient's) _____

Employer/School _____

Insurance Company _____

Plan/Group _____ ID/Certificate# _____

Secondary

Subscriber Name _____ Relationship to Patient _____ Birthdate _____

Address (if different from patient's) _____

Employer/School _____

Insurance Company _____

Plan/Group _____ ID/Certificate# _____

DENTAL HISTORY

What is your primary dental concern? _____

_____

_____

_____

Name of previous Dentist _____

When was your last visit to the dentist? _____

MEDICAL HISTORY

Physician's name _____

Have you had any serious illness or operations? Yes ❒ No ❒ If yes, please explain _____

_____

(Women) Are you pregnant? Yes ❒ No ❒ Nursing? Yes ❒ No ❒ Taking Birth Control? Yes ❒ No ❒

Please list all medications whether prescribed or over the counter including herbal supplementation and vitamins:

_____

_____

_____

Are you allergic or have you reacted adversely to any medications? Yes ❒ No ❒ If yes, please explain _____

_____

Have you ever taken a medication to increase bone density? Yes ❒ No ❒ If yes, name of medication _____

_____

Do you have any bleeding disorder or are you taking any blood thinners? Yes ❒ No ❒ If yes, please explain _____

_____

Have you ever had any heart problems? Yes ❒ No ❒ If yes, please explain _____

_____

Do you have a latex allergy? Yes ❒ No ❒

Check if you have ever been treated for any of the following:

❒ Aids, HIV Exposure	❒ Blood disease	❒ Hepatitis Exposure	❒ Rheumatic fever
❒ Arthritis	❒ Diabetes	❒ Environmental allergin	❒ Stroke
❒ Artificial heart valves	❒ Epilepsy	❒ Kidney disease	❒ Thyroid Problems
❒ Artificial joints	❒ Fainting	❒ Liver disease	❒ Tuberculosis
❒ Asthma	❒ Headaches	❒ Pacemaker	❒ Currently a smoker
❒ Anxiety	❒ Heart murmur	❒ Psychiatric care	❒ Former smoker
❒ Cancer	❒ High/Low blood-pressure	❒ Respiratory disease	❒ Others _____

CONSENT

I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge. I will hereby advise the office of any and all medical changes at each appointment. I hereby authorize direct payment from my dental insurance company to **Interlake Dental Centre** and further authorize of any and all information requested by the insurance company for processing of my dental claims.

For the principal intent of assisting with care, information may be disclosed to other health care providers, related health professionals, laboratories, pharmacies, financial institutions and dental insurance companies as may be required. I consent to my physician being contacted regarding any specific medical questions.

I understand that I am financially responsible for all fees, regardless of my insurance coverage. I also realize that it is my responsibility to be familiar with my policy. Payment is due at the time of service. If I have insurance, any and all co-payments and/or deductibles are due at the time of service. A fee will be charged for a missed appointment or failure to provide 2 business days' notice prior to a change of appointment.

Patient/Parent Signature: _____ Date _____

INTERLAKE
DENTAL CENTRE

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