Carol Rodriguez
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(250) – 412 - 3740
www.wedh.ca

Personal Information

First Name: _____ Last Name: _____ Date of Birth: D _____ M _____ Y _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone: C: _____ H: _____ W: _____ Email: _____

(If under 18 years of age)
Parent or Legal Guardian: _____

Preferred way of contact: _____ Preferred Day/Time: _____

Are you available on short notice? Yes_____ No_____

Physician: _____ Phone: _____

Dentist: _____Phone: _____

Specialist: _____ Phone: _____

Referred by: _____

INSURANCE
Do you have dental insurance?: Yes _____ No_____

Person responsible for the account: _____

Primary dental insurance:

Insurance Name: _____
Name of Insured: _____
Date of Birth: D _____ M _____ Y _____
Employer: _____
Group Policy# _____

Secondary dental insurance:

Insurance Name: _____
Name of Insured: _____
Date of Birth: D _____ M _____ Y _____
Employer: _____
Group Policy# _____

EMERGENCY CONTACT
In case of emergency please contact:

Name: _____Phone: _____ Relationship: _____

CONSENT

I authorized West End Dental Hygiene Inc. to collect and release information relating to my dental and medical health, like:

- **Health history**
- **X-Ray**
- **Intraoral images**

I understand that there may be necessary communication between my hygienist, general dentist, specialist, dental laboratories, dental benefit administrator and insurer carrier.
The purpose of information exchange is for treatment planning, long term follow-ups, research and/or educational purposes.
All personal information is protected and safeguarded by the involved health professionals.
Declaration:
I confirm that I have seen a dentist/dental specialist within the last year.

Print Name: _____ Date: _____

Signature: _____

Updates:

_____ _____ _____ _____

_____ _____ _____ _____