DR. HARLEEN BRAICH, BDS, DMD & ASSOCIATES

2-2525 Dobbin Rd. West Kelowna, BC V4T 2G1 **PHONE:** (250) 768-7007 **FAX:** (250)768-0578

PATIENT REGISTRATION FORM

PATIENT LAST NAME: ________________________ **FIRST:** _______________________ **Middle:**___ **Preferred Name:** _________________

Mr. Miss Is this your legal name? YES or NO If not, what is your legal name? ______________________

Marital Status: Single Married Other _______ **Birth Date:** ___________________ **Age:** _____ **Male / Female**

Day/Month/Year

Street Address: ____________________________________Cell #_________________________Home #___________________________

Address cont. or P.O. Box: ______________**City:** ______________________________**Prov :** _________**Postal Code:** _________________

EMAIL: ____

EMERGENCY CONTACT: ***FULL NAME*** _______________________________ ***PHONE #***____

Employer Company Name: ___________________________________ **Employer Phone #:**_____________________________________

Occupation: ____ **YOUR HEALTH CARE #:** __________________________________

How did you hear about us? (Please check one box): ☐ **Radio Ad** ☐ **Referral by Medical Doctor**

☐ **Family** ☐ **Friend** ☐ **Website** ☐ **Newspaper Ad** ☐ **Yellow Pages** ☐ **Google** ☐ **Other**

Other family members seen here: ____

PREVIOUS DENTAL CLINIC NAME: ____

City___________________________

Dr./Dentist Name: __________________________ Phone number:_______________________

INSURANCE INFORMATION

(Please fill out or give your insurance card to the receptionist)

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Name of PRIMARY INSURANCE (if applicable): INSURANCE COMPANY:_______________________________	Name of SECONDARY INSURANCE (if applicable): INSURANCE COMPANY:_______________________________
Subscriber's Name: ___________________________________	Subscriber's Name: ___________________________________
Subscriber's Birth Date: _______________________________ Day/Month/Year	Subscriber's Birth Date: _______________________________ Day/Month/Year
Employer: ____	Employer: ____
Group/Policy No.: _________________________________	Group/Policy No: __________________________________
ID/Certificate No: __________________________ ______ Patient's relationship to subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐	ID/Certificate No ; ___________________________________ Patient's relationship to subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐

OUR OFFICE IS HAPPY TO HELP YOU WHEN IT COMES TO YOUR DENTAL INSURANCE. IN MOST CASES, WE ARE ABLE TO DIRECT BILL INSURANCE COMPANIES WITH SOME RESTRICTIONS. WE DO ASK THAT YOU PAY YOUR CO-PAY AT THE TIME OF SERVICE IF YOU ARE TAKING ADVANTAGE OF DIRECT BILLING.

Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that takes into consideration your overall health and well-being.

Within the past year, have there been any changes in your general health: Please circle one: YES or NO

What is the date (or approximate date) of your last medical exam? ____

Name of Medical Doctor & Clinic: ____

Have you ever had complications following dental treatment? ____
Are you currently under the care of a physician due to a specific condition? ____
Have you been hospitalized within the last 5 years due to a surgery or illness? _______________________________________

WOMEN ONLY: Are you pregnant? Please circle one: YES or NO If yes, when is the due date? ___________________

Please list all medications: OR we can request a print out from your pharmacy please let us know who to contact.

____

____

Do you have any other health issues or allergies? ____

____

Please indicate if you have experienced any of the following:

___ Alcohol Abuse
___ Artificial Heart Valve, repaired Heart Defect
___ Artificial Prosthesis
___ Asthma or Sinus problems
___ Arthritis or Rheumatism
___ Anemia or other Blood Disorder
___ Any lumps or swelling in the mouth
___ Cancer
___ Chemotherapy
___ Diabetes or Glaucoma
___ Digestive Disorders (ie: Gastric reflux)
___ Emotional problems
___ Exhausted or fatigued (often)
___ Emphysema, Sarcoidosis
___ Epilepsy
___ Headaches (frequency ______________)
___ Head or Neck injuries
___ Heart Murmur
___ Heart problems or Stroke
___ Hepatitis A, B or C
___ High Blood Pressure
___ History of infective Endocarditis
___ High Cholesterol or taking Statin Drugs
___ Hormone Deficiency
___ Jaundice
___ Kidney Disease
___ Liver Disease
___ Low Blood Pressure
___ Nervous problems
___ Neurologic problems (Attention Deficit Disorder)
___ Osteoporosis
___ Pacemaker or Implantable Defibrillator
___ Prolonged bleeding from a minor cut
___ Psychiatric Treatment
___ Recreational Drug Use
___ Tested HIV positive
___ Thyroid, Parathyroid Disease or Calcium Deficiency
___ Tobacco use
___ Tuberculosis or Lung Disease
___ Use of bisphosphonates (ie: Fosamax)
___ Viral Infections and Cold Sores
___ X-ray Radiation Therapy

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

I AUTHORIZE WESTBANK DENTAL AND IMPLANT CENTRE TO DIRECT BILL MY INSURANCE FOR ANY TREATMENT COMPLETED AT THIS OFFICE. AS A PATIENT AND I AGREE TO PAY THE AMOUNT NOT COVERED BY MY INSURANCE PLAN. I ACKNOWLEDGE THAT I AM DIRECTLY RESPONSIBLE TO PAY FOR SERVICES RENDERED FOR ALL TREATMENT AS A PATIENT OF THIS OFFICE.

PATIENT SIGNATURE: ____ DATE: ________________________