Patient Information: *Please PRINT clearly*

Last Name: _____

First Name: _____ MI: _____

Age:	Date of Birth:		Social Security #: - -
Circle One: Male or Female	*Check One:* ◯ Married ◯ Single ◯ Child ◯ Other		
Address:			Apt #:
City:	State:	Zip:	Phone #: - -
Cell Phone #: - -	E-mail Address:		
Primary Doctor:			Phone #: - -
Emergency Contact:	Phone #: - -		Relationship:
Employer:	Business Phone #: - -		
Full or Part-time Student: Y or N	If yes, where?:		

Dental History:

Date of last complete dental exam: _____ Are you apprehensive about dental treatment? Y or N

What problems are you having now? *(Describe)*: _____

_____

Do your gums feel tender or bleed easily?: Y or N How long?: _____

Are you sensitive to: ◯ Hot ◯ Cold ◯ Sweets ◯ Pressure

Do you wear dentures?: Y or N Full or Partial How old are they?: _____

Medical History: *Circle any of the following which you have had or presently have:*

Heart Disease/Attack
Angina Pectoris
High Blood Pressure
Heart Murmur
Rheumatic Fever
Congenital Heart Lesion
Mitral Valve Prolapse
Artificial Heart Valve
Chemotherapy/Radiation
Heart Surgery
Tempro Mandibular Joint Problem (TMJ)

Artificial Joints
Anemia
Stroke
Kidney Trouble
Ulcers
HIV/AIDS
HEP A
HEP B
HEP C
STD

Blood Transfusion
Drug Addition/Alcoholism
Hemophilia
Fever Blisters
Epilepsy
Psychiatric Treatment
Glaucoma
Cancer
Heart Pacemaker
Emphysema

Sinus Trouble
Thyroid Disease
Hay Fever
High Cholesterol
Arthritis
Asthma
Allergies/Hives
Diabetes
Latex Allergy
Penicillin Allergy

Are you under the care of a physician now?: Y or N Are you pregnant?: Y or N

What are you currently being treated for?: _____

List current medications: _____

Are you allergic to any medication?: _____

List any other known allergies: _____

Have you ever had an adverse reaction to local anesthetics?: _____

Do you require antibiotic prophylaxis? Why?: _____

Are you taking blood thinners such as Coumadin, Aspirin, or Plavix?: _____

Are you taking any antiosteoporosis medications? (Fosamax, etc.): _____

Patient Signature: _____ **Date:** _____

Insurance Information:

Note: The following information pertains to the individual who is the primary subscriber of the insurance policy. It also pertains to the parent or guardian when the patient is under the age of 18.

Last Name:	First Name:		MI:
Age:	Date of Birth:		Social Security #: - -
Circle One: Male or Female	*Check One:* ◯ Married ◯ Single ◯ Child ◯ Other		
Address:			Apt #:
City:	State:	Zip:	Phone #: - -
Cell Phone #: - -	E-mail Address:		
Employer:		Business Phone #: - -	
Relationship to Patient:			

Name of Patient's Insurance Carrier: _____

Group #: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: ____-____-____

IF YOU HAVE A SECONDARY INSURANCE PLEASE LET US KNOW

If you have insurance, we try to calculate your percentage (due at the time of service) as close as possible. Example: Your deductible, co-payments and annual maximum per calendar year. In the event that there is a remaining amount not paid by the insurance you will receive a billing statement. In the event that the balance becomes over 90 days past due your account may be forwarded to a collections agency.

Financial Policy/Authorization:

I have received the information on the questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the Dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the Dentist as soon as possible.

I authorize the insurance company indicated on this form to pay the Dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the Dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance, and that payment are due at the time of treatment, unless prior arrangements have been made.

Signature: _____ **Date:** _____

How Did You Hear About Westside Dental?:

◯ Newspaper ◯ Flyers ◯ Brochure ◯ Posters ◯ Friend ◯ Relative

◯ Other *(Please Specify)*: _____