

DENTAL WEST

Smile Well

Thank you for trusting us with your dental care.
We promise to do our best to provide you with
the finest care available. If you have any
questions, please do not hesitate to call us.

Date _____

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____ DOB _____ Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

Sex M F Married Widowed Single Minor
 Separated Divorced

E-mail _____ Cell Phone (____) _____ Patient SSN _____

Employer/School _____ Employer/School Phone (____) _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ SSN _____ Employer _____

Work Phone (____) _____ Whom may we thank for referring you? _____

Person(s) to contact in case of emergency _____ Phone(s) (____) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (____) _____

Drivers License # _____ SSN _____ DOB _____ Bank _____

Employer _____ Work Phone (____) _____

Currently a patient in our office Yes No E-mail _____ Cell Phone (____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

DOB _____ SSN _____ Employer _____ Date Employed _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

DOB _____ SSN _____ Employer _____ Date Employed _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Name _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath Yes No

Bleeding Gums Yes No

Blisters on lips or mouth Yes No

Burning sensation on tongue Yes No

Chew on one side of mouth Yes No

Cigarette, pipe, or cigar smoking Yes No

Clicking or popping jaw Yes No

Dry mouth Yes No

Fingernail biting Yes No

Food collection between teeth Yes No

Foreign objects Yes No

Grinding teeth Yes No

Gums swollen or tender Yes No

Jaw pain or tiredness Yes No

Lip or cheek biting Yes No

Loose teeth or broken fillings Yes No

Mouth breathing Yes No

Mouth pain, brushing Yes No

Orthodontic treatment Yes No

Pain around ear Yes No

Periodontal treatment Yes No

Sensitivity to cold Yes No

Sensitivity to heat Yes No

Sensitivity to sweets Yes No

Sensitivity when biting Yes No

Sores or growths in your mouth Yes No

How often do you floss? _____

How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Anemia Yes No

Arthritis, Rheumatism Yes No

Artificial Heart Valves Yes No

Artificial Joints Yes No

Asthma Yes No

Back Problems Yes No

Bleeding abnormally, with extractions or surgery Yes No

Blood Disease/Hemophilia Yes No

Cancer Yes No

Chemical Dependency Yes No

Chemotherapy Yes No

Circulatory Problems Yes No

Congenital Heart Lesions Yes No

Cortisone Treatments Yes No

Contact lenses Yes No

Cough, persistent or bloody Yes No

Diabetes Yes No

Emphysema Yes No

Epilepsy Yes No

Fainting or dizziness Yes No

Glaucoma Yes No

Headaches Yes No

Heart Murmur Yes No

Heart Problems Yes No

Hepatitis Type _____ Yes No

Herpes Yes No

High Blood Pressure Yes No

HIV/AIDS Yes No

Jaundice Yes No

Jaw Pain Yes No

Kidney Disease Yes No

Liver Disease Yes No

Low Blood Pressure Yes No

Mitral Valve Prolapse Yes No

Nervous Problems Yes No

Pacemaker Yes No

Pregnant Yes No

Psychiatric Care Yes No

Radiation Treatment Yes No

Respiratory Disease Yes No

Rheumatic Fever Yes No

Scarlet Fever Yes No

Shortness of Breath Yes No

Sinus Trouble Yes No

Skin Rash Yes No

Special Diet Yes No

Stroke Yes No

Swollen Feet or Ankles Yes No

Swollen Neck Glands Yes No

Thyroid Problems Yes No

Tonsillitis Yes No

Tuberculosis Yes No

Tumor or growth on head or neck Yes No

Ulcer Yes No

Venereal Disease Yes No

Weight Loss, unexplained Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

- Aspirin
- Barbiturates (Sleeping Pills)
- Codeine
- Iodine
- Latex
- Local Anesthetic
- Penicillin
- Sulfa
- Other _____



FINANCIAL AND OFFICE POLICY

Payment or estimated patient portion is due at the time of service.

Payments can be made by:

- Cash or Check
- Credit Card – Visa, MasterCard, American Express and Discover
- For treatment with takes two or more visits, crowns, bridges, dentures, etc., one half of the balance will be expected at the first appointment and the remaining balance at the final appointment.
- Payment plans available with Care Credit. Three, six, twelve and eighteen month plans with no interest. Please ask for application.

All returned checks will have a \$25.00 service charge.

All accounts must be paid within 30 days of treatment. Finance charges of 18% per year will be applied.

All accounts over 60 days will be turned to a collection agency chosen by DentalWest.

I authorize DentalWest or any collection agencies used by the office to contact me by telephone or cellular telephone for billing activities or payment arrangements.

A \$50.00 charge will apply for all appointments cancelled without a 24 hour notice.

I understand that I will be given an estimate of treatment and that I am responsible for the total fees regardless of insurance coverage. I further understand that there may be contract limitations that will prevail over this estimate of insurance coverage. I am aware that DentalWest submits my insurance for payment as a complimentary service and that an estimate is based on information given by my insurance company over the phone or via internet. **It is my responsibility to know my insurance policy.**

I authorize the DentalWest to release to my insurance company, any information or records of any treatment rendered to me for dental care. I authorize payment of insurance benefits to DentalWest.

I have read the above financial and office policy and agree to its content.

Signature of patient or responsible party

Date



NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our *Privacy Officer*.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

I, _____, acknowledge the Notice of Privacy Practices. (Print Patient Name)

Patient or legally authorized signature

Date

Printed name if signed on behalf of the patient

Relationship

ADDITIONAL DISCLOSURE AUTHORIZATION:

Authorized to discuss your dental treatment and billing with:

_____ Immediate Family

_____ Spouse Only

_____ Other: _____

This form will be retained in your medical record.