



Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Please print all information.

Patient Information

Full name of patient _____ Date _____
Address _____ City _____ State _____ Zip _____
Sex Female Male Birthdate _____ E-mail _____
Home phone _____ Cell phone _____ Work phone _____
Do you prefer to receive calls at Home Work Cell No preference
 Minor Single Married Other Social Sec. # or Driver Lic. # _____
Employer/School _____ Occupation _____
Employer/School Address _____ City _____ State _____ Zip _____
Spouse or parent/guardian _____
Person to contact in case of emergency _____ Phone _____
Who referred you to us? _____

Responsible Party

Name of person responsible for this account _____
Relationship to patient _____ Phone _____
Address _____ City _____ State _____ Zip _____
Name of employer _____ Work phone _____

Insurance Information

Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security # _____ Date employed _____
Name of employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
Your deductible \$ _____ Max. annual benefit \$ _____ How much have you used? \$ _____

Additional Insurance

Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security # _____ Date employed _____
Name of employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
Your deductible \$ _____ Max. annual benefit \$ _____ How much have you used? \$ _____

Dental History

Name _____ Age _____ Date of last exam _____

Former Dentist _____ Date of last dental X-rays _____

Reason for today's visit _____

How often do you brush? _____ How often do you floss? _____

Please check any of the following conditions that apply to you:

- | | | |
|---|--|---|
| <input type="radio"/> Bad breath | <input type="radio"/> Grinding teeth | <input type="radio"/> Sensitivity to heat |
| <input type="radio"/> Bleeding gums | <input type="radio"/> Loose teeth or broken fillings | <input type="radio"/> Sensitivity to sweets |
| <input type="radio"/> Clicking or popping jaw | <input type="radio"/> Periodontal treatment | <input type="radio"/> Sensitivity when biting |
| <input type="radio"/> Food collection between teeth | <input type="radio"/> Sores or growths in your mouth | <input type="radio"/> Sensitivity to cold |

Medical History

Physician _____ Date of last visit _____

List all medications you are currently taking: _____

Allergies _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Please check if you have had any of the following:

- | | | | |
|---|--|---|--|
| <input type="radio"/> AIDS | <input type="radio"/> Congenital Heart Lesions | <input type="radio"/> Hepatitis | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Anemia | <input type="radio"/> Cortisone Treatments | <input type="radio"/> Hernia Repair | <input type="radio"/> Scarlet Fever |
| <input type="radio"/> Arthritis, Rheumatism | <input type="radio"/> Cough, Persistent | <input type="radio"/> High Blood Pressure | <input type="radio"/> Shortness of Breath |
| <input type="radio"/> Artificial Heart Valves | <input type="radio"/> Cough up blood | <input type="radio"/> HIV Positive | <input type="radio"/> Skin Rash |
| <input type="radio"/> Artificial Joints | <input type="radio"/> Diabetes | <input type="radio"/> Jaw Pain | <input type="radio"/> Stroke |
| <input type="radio"/> Asthma | <input type="radio"/> Epilepsy | <input type="radio"/> Kidney Disease | <input type="radio"/> Swelling Feet/Ankles |
| <input type="radio"/> Back Problems | <input type="radio"/> Fainting | <input type="radio"/> Liver Disease | <input type="radio"/> Thyroid Problems |
| <input type="radio"/> Bleeding Abnormally | <input type="radio"/> Glaucoma | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Tobacco Habit |
| <input type="radio"/> Blood Disease | <input type="radio"/> Headaches | <input type="radio"/> Nervous Problems | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Cancer | <input type="radio"/> Heart Murmur | <input type="radio"/> Pacemaker | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Chemical Dependency | <input type="radio"/> Heart Problems | <input type="radio"/> Psychiatric Care | <input type="radio"/> Ulcer |
| <input type="radio"/> Chemotherapy | Describe: | <input type="radio"/> Radiation Treatment | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Circulatory Problems | <input type="radio"/> Hemophilia | <input type="radio"/> Respiratory Disease | |

Have you ever taken any of these medications?

- | | | | | |
|-------------------|---------------------------------------|---------------------------------|--------------------------------|-----------------------------|
| Diet Medications: | <input type="radio"/> Dexfenfluramine | <input type="radio"/> Fen-phen | <input type="radio"/> Pondimin | <input type="radio"/> Redux |
| Blood Thinners: | <input type="radio"/> Coumadin | <input type="radio"/> Warfarin | | |
| Other: | <input type="radio"/> Levoxyl | <input type="radio"/> Synthroid | | |

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with the insurance company/ies named on page one of this form and I assign directly to Westways Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Westways Dental may use my health care information and may disclose such information to the named insurance company/ies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent/Guardian, or Personal Representative _____

Date _____

Print name of person signing above _____

Relationship to patient _____