DENTAL WEST
Smile Well

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Date/Fecha___/___/___

Patient Information/Información de Paciente

Name/Nombre_____ Date Of Birth/Fecha de Nacimiento ___/___/___

Address/Domicilio_____ Marital Status: ☐ Married ☐ Single ☐ Child

City/Cuidad_____ State/Estado_____ Zip Code/Código_____ Sex: ☐ Male ☐ Female

SSN/Numero de Seguro Social _____-_____-_____ Employer/Empleo_____

Day-time Phone/Numero de Teléfono (___)_____-_____ Cell Phone/ Numero de Cellular (___)_____-_____

E-mail _____ Emergency Contact _____
Phone Number

Source of Referral _____

Please complete if Patient is a Minor/Por Favor complete si Paciente es Menor de Edad

Parent (Guardian) Name/Nombre de Padre (Guardian)_____

Date of Birth/Fecha de Nacimiento ___/___/___ SSN/Numero de Seguro Social _____-_____-_____

Cell Phone/Numero de Cellular (___)_____-_____ ☐ Married ☐ Single

Primary Insurance/Aseguranza Primaria

Subscriber Name_____ Date of Birth ___/___/___

Insurance Carrier Name _____ Group #/Local #_____

Employer Name _____ SSN _____-_____-_____ Insurance ID#_____

Secondary Insurance/Aseguranza Secundaria

Subscriber Name_____ Date of Birth ___/___/___

Insurance Carrier Name _____ Group #/Local #_____

Employer Name _____ SSN _____-_____-_____ Insurance ID#_____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
Name of Physician/and their specialty _____
Most recent physical examination _____ Purpose _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

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

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam _____ /_____ /_____ Date of most recent x-rays _____ /_____ / _____
Date of most recent treatment (other than a cleaning) _____ / _____ / _____
I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**

PERSONAL HISTORY

1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____	☐	☐
2.	Have you had an unfavorable dental experience? _____	☐	☐
3.	Have you ever had complications from past dental treatment? _____	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	☐	☐
6.	Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	☐	☐

GUM AND BONE

7.	Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10.	Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11.	Have you ever experienced gum recession? _____	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐

TOOTH STRUCTURE

14.	Have you had any cavities within the past 3 years? _____	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20.	Do you frequently get food caught between any teeth? _____	☐	☐

BITE AND JAW JOINT

21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26.	Are your teeth developing spaces or becoming more loose? _____	☐	☐
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? __	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30.	Do you clench or grind your teeth together in the daytime or make them sore? _____	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ___	☐	☐
32.	Do you wear or have you ever worn a bite appliance? _____	☐	☐

SMILE CHARACTERISTICS

33.	Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____	☐	☐
34.	Have you ever whitened (bleached) your teeth? _____	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
36.	Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

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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
- Payment plans available with Care Credit. Three, six, twelve, eighteen and twentyfour month plans with no interest. Please ask for application.

All returned checks will have a $35.00 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

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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.

Last Update: ___/___/___
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