Westgate Family Dental New Patient Form

About You

Today's Date: File #:

Patient Name:

What You Prefer To Be Called: ❑ Male ❑ Female

Birthdate: Age: SS#:

Mailing Address:

City: State: Zip:

Home Phone #: Cell Phone #:

Work Phone: #: Ext. Other Phone #:

E-Mail Address:

Referred By:

Employer: How Long?

Employer's Address:

City: State: Zip:

Occupation:

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name

Do you have children? ❑ No ❑ Yes How Many? _____

Account Information

Person ultimately responsible for account:

Name:

Relation:

Billing Address:

City: State: Zip:

SS #: Driver's License #:

Work Phone #:

Payment Method: ❑ Cash ❑ Check

❑ Credit Card - Card #_____(if accepted)

_____ *(initials)* I hereby authorize assignment of my insurance rights and benefits directly to the provide for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. (if offered at this office.)

Insurance Information

Co. Name:

Address:

City: State: Zip:

Phone #: Insured's SS #:

Group # (Plan, Local or Policy #):

Insured's Name:

Relation: Date of Birth:

Insured's employer:

Secondary Dental Insurance

Co. Name:

Address:

City: State: Zip:

Phone #: Insured's SS #:

Group # (Plan, Local or Policy #):

Insured's Name:

Relation: Date of Birth:

Insured's employer:

In the event on an Emergency

Who should we contact?

Relation:

Home Phone #:

Cell Phone #:

Work Phone #: Ext.

Name of your Medical Doctor:

M.D.'s Phone #:

Please continue on back.

Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation Are you in pain? ❑ No ❑ Yes How Long? _____

Please indicate (❑ with checkmark) any of the following problems:

❑ Discomfort, clicking or popping in jaw
❑ Lost/Broken Filling(s)
❑ Stained teeth
❑ Red, swollen or bleeding gums
❑ Other:
❑ Teeth grinding
❑ Locking Jaw
❑ Sensitive tooth, teeth or gums
❑ Ringing in Ears
❑ Bad breath
❑ Blisters/Sores in or around the mouth
❑ Broken/Chipped tooth

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ Name _____ Phone _____

Last Dental exam: _____ Last Dental X-rays: _____

Times a day you brush? _____ Times a week you floss? _____ What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Medical History

Are you taking any of the following medications?

❑ Nerve pills
❑ Pain killers (including aspirin)
❑ Muscle relaxers
❑ Stimulants
❑ Blood thinners
❑ Tranquillizers
❑ Insulin
❑ Other(s), please list: _____

Do you have or have you had any of the following diseases, medical conditions or procedures? (Check all that apply.)

❑ Heart Attack / Stroke
❑ Heart Surg. / Pacemaker
❑ Heart Murmur
❑ Rheumatic Fever
❑ Mitral Valve Prolapse
❑ Artificial Valves
❑ Heart Disease
❑ Congenital Heart Defect
❑ Chest Pains
❑ Scarlet Fever
❑ Nervousness
❑ Thyroid Problems
❑ Kidney Problems
❑ Liver Problems
❑ Respiratory Problems
❑ Sinus Problems
❑ Stomach Problems / Ulcers
❑ Psychiatric Problems
❑ Venereal Disease
❑ Alcohol / Drug Abuse
❑ Tuberculosis TB
❑ Jaw Problems TMJ / TMD
❑ Cancer / Tumors
❑ Shingles
❑ Hepatitis
❑ HIV+/ AIDS / ARC
❑ Arthritis / Rheumatism
❑ Artificial Bones /Joints
❑ Emphysema
❑ Fainting / Seizures / Epilepsy
❑ Severe / Frequent Headaches
❑ Frequent Neck Pain
❑ Back Problems
❑ Cosmetic Surgery
❑ Xray or Cobalt Treatment
❑ Chemotherapy
❑ Asthma
❑ Difficulty Breathing
❑ Diabetes / Hypoglycemia
❑ Leukemia
❑ Anemia
❑ High / Low Blood Pressure
❑ Bleeding Problems
❑ Glaucoma

Please list any other medical condition(s) you have or ever had: _____

_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Dental Anesthetics

❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/How used?_____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ❑ Yes ❑ No

Have you ever taken the drug Phen-fen and or Redux? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? _____

Are you Pregnant? ❑ Yes/How long? ❑ No Are you nursing? ❑ Yes ❑ No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

UPDATE *(Office Use)*

_____ ____/____/____
Initials Date

_____
Comments

_____ ____/____/____
Initials Date

_____
Comments

_____ ____/____/____
Initials Date

_____
Comments

Signature _____ Date _____/_____/_____

❑ Adult patient ❑ Parent of Guardian ❑ Spouse