West One Family Dental

Patient Information

Today's Date_____

Patient's Name_____Marital Status S M D W

Address_____
Street City State Zip

Home Phone_____Work Phone_____Cell Phone_____

Birthdate_____Social Security#_____email_____

If minor, parent or guardian's name_____I prefer to be called _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Please FILL OUT in full - DO NOT write same

Name_____Relationship to patient_____

Residence Address_____
Street City State Zip

Mailing Address_____
Street City State Zip

Home Phone_____Work Phone_____Cell Phone_____

Birthdate_____Social Security#_____email_____

Employer_____Position_____No. Years Employed_____

Spouse's Name_____

Birthdate_____Social Security#_____Work Phone_____

Employer_____Position_____No. Years Employed_____

Insurance Information

-You are responsible for knowing what your Insurance does & does not pay-

Primary Insured's name_____Insurance ID#_____

Insured's Employer_____Insured's Birthdate_____

Insurance Company_____Phone#_____Group#_____

Address to submit Dental claims_____

2nd Insurance- Insured's name_____Insurance ID#_____

Insured's Employer_____Insured's Birthdate_____

Insurance Company_____Phone#_____Group#_____

Address to submit Dental claims_____

Local contact

Contact Person (not at your address) _____Relation to patient_____

Home phone_____Work Phone_____Cell Phone_____

Signature_____**Date**_____

********** Please complete Health History on backside **********

Medical History:

Do you have a personal physician? Y N
Physician's name_____
Your current physical health is:
_____Good _____Fair _____Poor
Are you currently under the care of a physician? Y N
Please explain:_____

Do you take any prescription/over the counter Drugs? Y N
Please list each one: _____

Have you had or been treated for: (Please circle)

Alcohol / Drug abuse	Heart Disease
Asthma	Heart Murmur
Blood Pressure- High / Low	Heart Valve
Bleeding / Clotting Disorder	Hepatitis A B C
Depression / Psychiatric problems	High Cholesterol
Diabetes	HIV / AIDS
Dry Mouth	Rheumatic Fever
Fibromyalgia	Stroke
Immunocompromised Disease	Tuberculosis

Have you had a joint replacement? Y N Date _____

Have you been told by your physician that you require antibiotics before dental treatment? Y N If Yes- what antibiotic do you take? _____

Have you ever been treated for Osteoporosis? Y N
Were you treated with bisphosphonates? Y N
(Boniva, Fosamax, Reclast, Actonel, Zometa, _____)

Please list any disease, condition or problem you have that is not listed above: _____

Have you ever had a serious illness, operated on, or been hospitalized? _____

Women: Are you taking birth control pills? Y N
Are you pregnant? Y N
Are you nursing? Y N

Are you allergic to any of the following? (Please circle)

Aspirin	dental anesthetics	metals / jewelry
Tylenol	penicillin / antibiotics	plastics / Latex
Barbiturates	sedatives or sleeping pills	
Codeine or other narcotics		

Is there anything else your allergic to? _____

Dental History:

Why are you seeking dental care at this time?
Do you have any specific concerns or questions you would like to have answered? Y N_____

Your current dental health is:
_____Good _____Fair _____Poor

Are you currently in Pain? Y N

Date of your last dental checkup / cleaning? _____

Have you had any difficulty or unfavorable experiences with previous dental work? Y N Please explain: _____

Why did you leave your previous dentist?_____

Do you use tobacco? Y N Have you noticed any lumps / sores in your mouth? Y N

How many times a day do you brush? _____

How many time a week do you floss? _____

I understand that the information I've given here today is correct to the best of my knowledge. I also understand that this office upholds the **HIPAA**. By signing this form I consent to the use and disclosure of my information only as necessary to carry out treatment, payment activities and healthcare operations.

It is acceptable to discuss my health information with:

Name relationship

Payment is due in FULL at time of treatment.

If I have insurance I understand WOFD will bill my insurance, and I will make payment of the "ESTIMATED co-pay" at time of treatment. I understand **I am ultimately responsible for all charges** should my insurance not pay as estimated.

Signature and date

West One Family Dental is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC & ADA