westparkdental
your smile says it all

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Today's date:____/____/____and, who may we thank for referring you to our office?_____

PLEASE PRINT - COMPLETE ALL BLANKS

PATIENT INFORMATION

Name _____ Nickname _____
Address _____ City_____ State_____Zip_____
Date of Birth _____ Social Security Number _____
Home Phone _____Work phone _____ Cellular/Pager _____
When is the best time to call? _____ Where? _____
Employer_____ Occupation _____
Spouse's name _____ Your E-Mail Address _____
In the event of an emergency, is there someone who lives near you that we should contact?
Their Name _____ Relationship _____
Work number _____ Home number _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Company Name _____
Phone # _____ Group # _____
Insurance Co. Address _____ Birth date _____
Policy Holder's Name _____ Policy Holder's SS# _____
Name of Employer Group _____ Group No. _____
Please Provide Us With An Insurance Form or Coverage Card.

Secondary Insurance (if applicable)

Company Name _____
Phone # _____ Group # _____
Insurance Co. Address _____ Birth date _____
Policy Holder's Name _____ Policy Holder's SS# _____

PLEASE NOTE: Your signature is authorization for treatment and acceptance of responsibility of payment. In the case of minors, the person accompanying the minor is the responsible party.

Parent of Guardian if minor: I give permission to treat _____
Signed: **X**_____

• PAST DUE BALANCES - an interest charge of 1-1/2% per month will be added to all balances past 90 days.

DENTAL HISTORY

Why have you come to the dentist today? _____
The date of your last dental visit:_____ Previous Dentist's name _____
If you could wave a magic wand, and change anything about the appearance of your smile, what would you like to do?
_____

Would you like to whiten your teeth? ❑ Yes ❑ No
Do your gums bleed when you brush? ❑ Yes ❑ No

Photo release: In exchange for good and valuable consideration, the receipt and adequacy of which is acknowledged the undersigned, together with his/her heirs and assigns, grants to Westpark Dental the right and license to display photographs of the undersigned to advertising and/or similar commercial and educational purpose. The undersigned understands and agrees that such photographs will be displayed to and be viewed by, the patients, prospective patients, dental and office staff and other persons who may enter the office of the dentist.

Patient (parent / guardian if minor): _____ Date _____

MEDICAL HISTORY

Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your response to this questionnaire and there may be additional questions concerning your health.

Name of personal physician: _____
Phone # _____

Please list all medications you are currently taking:
_____
_____
_____
_____
_____
_____
_____
_____

Do you smoke? ❑ Yes ❑ No

How much? Packs per day _____

Do you use smokeless tobacco products? ❑ Yes ❑ No

Blood Pressure:
Date: _____ _____

Please check any of the following diseases or medical problems you have been treated for.

Heart Conditions:
- ❑ Heart Attack
- ❑ Heart Bypass Surgery
- ❑ Heart Valve Replacement
- ❑ Congestive Heart Failure
- ❑ High Blood Pressure
- ❑ Pacemaker

Other Conditions:
- ❑ Hepatitis: A__ B__ C__
- ❑ Epilepsy
- ❑ Diabetes: Type I __ II __
- ❑ Stroke
- ❑ Ulcers/Colitis
- ❑ Asthma
- ❑ Emphysema

- ❑ Cancer: Type _____
- ❑ Artificial Joints: Type _____ Date: _____

Please list any other medical conditions, recent surgeries, or hospitalizations not listed above:
_____
_____
_____
_____
_____
_____

Are you allergic to any of the following:
- ❑ Penicillin
- ❑ Latex
- ❑ Codeine
- ❑ Ibuprofen/Motrin
- ❑ Erythromycin
- ❑ Aspirin

Please list any other drugs that you are allergic to ____
_____
_____
_____
_____