westparkdental
your smile says it all

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www.westparksmiles.com

Today's Date: ____/____/_____ Who May We Thank for Referring You To Our Office?_____

PLEASE PRINT

PATIENT INFORMATION

Name _____ Spouse's Name _____

Address _____ City_____ State_____Zip_____

Date of Birth _____ Social Security Number _____

Home Phone (_____) _____-_____ Work phone (_____) _____-_____ Cell Phone (_____) _____-_____

E-mail Address? _____ @ _____ . _____

How can we best contact you? ❒ Home Phone ❒ Work Phone ❒ Cell Phone ❒ Text ❒ E-mail

Employer_____ Occupation _____

In the event of an emergency, is there someone we should contact?

Name _____ Relationship _____

Home Phone (_____) _____-_____ Work phone (_____) _____-_____ Cell Phone (_____) _____-_____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Company Name _____

Phone (_____) _____-_____ Group # _____

Insurance company address _____

Policy Holder's Name (if different from above) _____

Policy Holder's SS or ID# _____ Policy holder Date of Birth ____/____/_____

Name of Employer _____

Please Provide Us With An Insurance Form or Coverage Card.

Secondary Insurance (if applicable)

Insurance Company Name _____

Phone (_____) _____-_____ Group # _____

Insurance company address _____

Policy Holder's Name _____ Policy Holder's SS# _____

Policy Holder's SS or ID# _____ Policy holder Date of Birth ____/____/_____

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.

Signed: **X**_____

Past Due Balances - are charged interest of 1-1/2% per month on balances past due 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: _____
Name of practice: _____
Phone (____) ____-_____ Fax (____) ____-_____
City _____ ST ___ ZIP _____
Please list all medications you are currently taking:

_____
_____
_____
_____
_____
_____
_____

Do you smoke? ❑ Yes ❑ No
If yes, how much? Packs per day _____
Do you use smokeless tobacco products? ❑ Yes ❑ No
Do you snore? ❑ Yes ❑ No
My snoring affects other people. ❑ Yes ❑ No
I have used CPAP. ❑ 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
- ❑ HIV/AIDS

- ❑ 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 ____

_____
_____
_____
_____