New Patient Form

Welcome!

WestSide Family Dental Group

Prevention Is Everything

About You

Today's Date:_____/_____/_____ File#:_____

Patient Name:_____
LAST FIRST MI

What You Prefer To Be Called:_____ ❑ Male ❑ Female

Birthdate:____/____/____ Age:____ SS#:_____

Mailing Address:_____

_____
CITY STATE ZIP

Home Phone #: (_____) _____

Work Phone #: (_____) _____Ext:_____

Cell Phone #: (____) _____

E-mail Address: _____

Referred By: _____

Employer:_____ How Long?_____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

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

Spouse's Name: _____

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

Account Info

Person ultimately responsible for account

Name: _____
LAST FIRST MI

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (_____)_____

Payment Method: ❑ Cash ❑ Check ❑ Card

_____ ____/____

❑ Credit Card - Enter card # above (if accepted)

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

Insurance Info or Membership

❑ **Insurance Patient**

Primary Dental Insurance

Co. Name:_____

Address:_____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID #:_____

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 ID #:_____

Group # (Plan, Local or Policy #)_____

Insured's Name:_____

Relation:_____ Date of Birth:___/___/___

Insured's Employer:_____

❑ **Membership Patient**

I acknowledge to have fully read and signed the Medical Retainer Agreement which is part of this New Patient Form presented to me by Westside Family Dental Group.

In Event Of Emergency

Whom should we contact?_____

Relation: _____

Home Phone #: (_____)_____

Work Phone #: (_____)_____

Cell Phone #: (____) _____

Who is your Medical Doctor: _____

Medical Doctor'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 any of the following problems:

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

❑ Other:_____
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

What medications are you taking? ❑ **Nerve pills** ❑ **Pain killers** (including aspirin) ❑ **Muscle relaxers**
❑ **Stimulants** ❑ **Blood thinners** ❑ **Tranquilizers** ❑ **Insulin** ❑ **Meds for Osteoporosis**
❑ **Other(s),** please list:_____
Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No
Do you have or have you had any of the following diseases, medical conditions or procedures?

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

Please list any other surgeries or medical conditions you have or ever had:_____
_____
Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin
❑ Dental Anesthetics ❑ Foods:_____ ❑ 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
For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had?_____
Are you pregnant? ❑ No ❑ Yes/How Long?_____ 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, collecting agency fees, interest in 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 completely correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in the information I have provided.

_____ I acknowledge that I have received a copy of the Summary of Privacy Notice.
Initials

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

_____ ____/____/____
Initials Date
_____
Comments

_____ ____/____/____
Initials Date
_____
Comments

_____ ____/____/____
Initials Date
_____
Comments