Westside Dental Health Assessment & Financial Policy

PATIENT'S INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI _____
DATE OF BIRTH: _____ AGE: _____ SS#: _____
CIRCLE: MALE FEMALE MARRIED SINGLE CHILD
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ CELL: _____ MESSAGE PHONE: _____
EMERGENCY CONTACT:
NAME: _____ PHONE: _____ RELATIONSHIP TO PT: _____
HOW DID YOU HEAR ABOUT WESTSIDE DENTAL: _____
DENTAL HISTORY
DATE OF LAST DENTAL EXAM/X-RAYS: _____
LIST ANY CURRENT DENTAL PROBLEMS: _____
DO YOU WEAR DENTURES? YES / NO IF YES: FULL OR PARTIAL AGE OF DENTURES: _____
MEDICAL HISTORY
PLEASE CHECK ALL QUESTIONS WITH YES OR NO IF YOU CURRENTLY **HAVE OR HAVE HAD** ANY OF THE FOLLOWING:

HEART DISEASE/ATTACK	Y	N	AIDS/HIV/ARC	Y	N	OSTEOPOROSIS	Y	N
ANGINA PECTORIS	Y	N	HEPATITIS	Y	N	EMPHYSEMA	Y	N
HIGH BLOOD PRESSURE	Y	N	BLOOD TRANSFUSION	Y	N	SINUS TROUBLE	Y	N
HEART MURMUR	Y	N	DRUG ADDICTION	Y	N	TUBERCULOSIS	Y	N
RHEUMATIC FEVER	Y	N	HEMOPHILIA	Y	N	HAY FEVER	Y	N
CONGENITAL HEART LEASION	Y	N	EPILEPSY/SEIZURES	Y	N	TYRIOD DISEASE	Y	N
ARTIFICAL HEART VALVE	Y	N	ANEMIA	Y	N	ARTHRITIS	Y	N
CHEMOTHERAPY/RADIATION	Y	N	CANCER	Y	N	GLAUCOMA	Y	N
CORTISONE THERAPY	Y	N	STROKE	Y	N	KIDNEY/LIVER PROBLEMS	Y	N
LEUKEMIA	Y	N	ULCERS	Y	N	DIABETES	Y	N
COSMETIC SURGERY	Y	N	ARTIFICIAL JOINT	Y	N	STENTS/METAL PLATES	Y	N
BRUISE EASILY	Y	N	ASTHMA	Y	N	TMJ	Y	N

ARE YOU PREGNANT? YES / NO IF YES, DUE DATE: _____

PLEASE LIST ANY OTHER MEDICAL PROBLEMS: _____

DO YOU TAKE **COUMADIN OR BLOOD THINNERS**? YES / NO

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING ASPIRIN AND OVER THE COUNTER MEDICATIONS:

_____

ARE YOU ***ALLERGIC*** TO, OR HAVE YOU REACTED ADVERSELY TO ANY MEDICATIONS SUCH AS:

ASPIRIN LOCAL ANESTHETIC ERYTHROMYCIN NITROUS OXIDE CODEINE PENICLLIN

PLEASE LIST ANY OTHERS: _____

HAVE YOU EVER PRE-MEDICATED FOR DENTAL TREATMENT? YES / NO

DO YOU HAVE A HISTORY OF ARTIFICIAL JOINT REPLACEMENT? YES / NO

ARE YOU ***ALLERGIC*** TO LATEX? YES / NO

DENTAL INSURANCE

INSURANCE COMPANY NAME: _____ ID#:_____

PLEASE HAVE YOUR INSURANCE CARD AVAILABLE FOR US TO COPY FOR YOUR CHART

POLICY HOLDER INFORMATION (IF NOT THE PATIENT)

NAME: _____

DATE OF BIRTH: _____ SS#: _____

RELATIONSHIP TO THE PATIENT: _____ EMPLOYER: _____

MEDICAL HISTORY AND HEALTH ASSESSMENT

I HAVE RECEIVED THE INFORMATION QUESTIONNAIRE REGARDING MY CURRENT AND PAST MEDICAL HEALTH. IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION WILL BE USED BY THE DENTIST TO HELP DETERMINE THE APPROPRIATE AND HEALTHFUL DENTAL TREATMENT FOR ME. I ALSO UNDERSTAND THAT IF THERE IS EVER ANY CHANGE IN MY MEDICAL STATUS I WILL INFORM THE DENTIST AND DENTAL STAFF PRIOR TO TREATMENT.

FINANCIAL POLICY/AUTHORIZATION

I AUTHORIZE THE INSURANCE COMPANY INDICATED ON THIS FORM TO PAY THE DENTIST (WESTSIDE DENTAL) ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

I UNDERSTAND THAT MY INSURANCE POLICY IS AN AGREEMENT BETWEEN ME AND MY INSURANCE COMPANY NOT WESTSIDE DENTAL, AND IT IS MY RESPONSIBILITY TO UNDERSTAND THE TERMS OF THIS POLICY. I ALSO UNDERSTAND THAT IF I HAVE ANY OUT-OF-POCKET EXPENSES, CO-PAYMENTS OR ANNUAL DEDUCTABLE I WILL BE REQUIRED TO PAY THESE AT THE TIME SERVICES ARE RENDERED. WESTSIDE DENTAL WILL ATTEMPT TO GIVE ME AN ACCURATE ESTIMATE OF ANY EXPENSES. I ALSO UNDERSTAND THAT THIS ESTIMATE IS NOT A GUARANTEE OF BENEFITS AND I WILL BE RESPONSIBLE FOR ANY EXPENSES NOT COVERED BY MY INSURANCE COMPANY. IN THE EVENT THAT THERE IS REMAINING BALANCE NOT PAID BY INSURANCE COMPANY, AND THE BILL BECOMES OVER 120 DAY OVERDUE, I MAY BE SENT TO COLLECTIONS.

I AUTHORIZE THE DENTIST (WESTSIDE DENTAL) TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHANGES WHETHER OR NOT PAID BY THE INSURANCE, AND THAT THE PAYMENTS ARE DUE AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____