Westways dental
quality dentistry & low fees

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Please print all information.

PATIENT INFORMATION

Date _____

Name *(last, first, middle initial)*

Address

City State Zip

Home Phone Cell Email

Date of Birth Social Security # Gender ❑ male ❑ female

Employer/School Phone

Spouse or Parent/Guardian

Emergency Contact Phone

Relationship of Emergency Contact to Patient ❑ spouse ❑ parent ❑ other

Who referred you to us?

RESPONSIBLE PARTY INFORMATION

Name *(last, first, middle initial)*

Address

City State Zip

Home Phone Cell Email

Date of Birth Social Security #

Employer Work Phone

Gender ❑ male ❑ female Relationship to Patient ❑ self ❑ spouse ❑ parent ❑ other

DENTAL INSURANCE INFORMATION

Please provide your card at the front desk so we may make a copy of it.

Medicaid? ❑ yes ❑ no

Primary Insurance Company

Address Phone

Subscriber's name Date of birth

Subscriber's SSN Employer

Patient's relationship to subscriber (check one) ❑ self ❑ spouse ❑ child ❑ other

Secondary Insurance Company

Address Phone

Subscriber's name Date of birth

Subscriber's SSN Employer

Patient's relationship to subscriber (check one) ❑ self ❑ spouse ❑ child ❑ other

DENTAL HISTORY

Name _____ Age _____ Date of last exam _____

Former Dentist _____ Date of last dental X-rays _____

Reason for today's visit _____

Please check any of the following conditions that apply to you:

- ❍ Bad breath
- ❍ Bleeding gums
- ❍ Clicking or popping jaw
- ❍ Food collection between teeth
- ❍ Grinding teeth
- ❍ Loose teeth or broken fillings
- ❍ Periodontal treatment
- ❍ Sores or growths in your mouth
- ❍ Sensitivity to heat
- ❍ Sensitivity to sweets
- ❍ Sensitivity when biting
- ❍ Sensitivity to cold

MEDICAL HISTORY

Physician _____ Date of last visit _____

Any allergies? Please list: _____

List all medications you currently take: _____

_____

Have you ever taken any of these medications? Check all that apply:

Diet Medications:	❍ Dexfenfluramine	❍ Fen-Phen	❍ Pondimin	❍ Redux
Blood Thinners:	❍ Coumadin	❍ Warfarin		
Osteoporosis:	❍ Fosamax	❍ Boniva	❍ Actonel	
Other:	❍ Levoxyl	❍ Synthroid	❍ Bisphosphonates	

(Women) Are you pregnant? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No Taking birth control pills? ❍ Yes ❍ No

Do you have (or have you ever had) any of the following? Check all that apply:

- ❍ AIDS
- ❍ Anemia
- ❍ Arthritis, Rheumatism
- ❍ Artificial Heart Valves
- ❍ Artificial Joints
- ❍ Asthma
- ❍ Back Problems
- ❍ Bleeding Abnormally
- ❍ Blood Disease
- ❍ Cancer
- ❍ Chemical Dependency
- ❍ Chemotherapy
- ❍ Circulatory Problems
- ❍ Congenital Heart Lesions
- ❍ Cortisone/Steroid Treatments
- ❍ Cough, Persistent
- ❍ Cough up blood
- ❍ Diabetes
- ❍ Epilepsy
- ❍ Fainting
- ❍ Glaucoma
- ❍ Headaches/Migraines
- ❍ Heart Murmur
- ❍ Heart Problems
  Describe:
- ❍ Hemophilia
- ❍ Hepatitis
- ❍ Hernia Repair
- ❍ High Blood Pressure
- ❍ HIV Positive
- ❍ Jaw Pain
- ❍ Kidney Disease
- ❍ Liver Disease
- ❍ Mitral Valve Prolapse
- ❍ Nervous System/Seizures
- ❍ Pacemaker
- ❍ Psychiatric Care
- ❍ Radiation Treatment
- ❍ Respiratory Disease
- ❍ Rheumatic Fever
- ❍ Scarlet Fever
- ❍ Shortness of Breath
- ❍ Skin Rash
- ❍ Stroke
- ❍ Swelling Feet/Ankles
- ❍ Thyroid Problems
- ❍ Tobacco Habit
- ❍ Tonsillitis
- ❍ Tuberculosis
- ❍ Ulcer
- ❍ Venereal Disease

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that a change in health or medications can affect dental treatment, and I agree to inform the dentist of any changes for myself, or my minor child, at future appointments.

I certify that I, and/or my dependent(s), have coverage with the insurance company/ies named on the first page of this form, and I assign directly to Westways Dental insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on insurance submissions. I authorize the use and disclosure of health care information to the named insurance company/ies and their agents for the purpose of determining benefits and obtaining payment. I acknowledge that I am financially responsible for all charges, including amounts not paid by insurance.

I grant permission to Westways Dental and its assignees to contact me as needed regarding my account, appointments, or treatment, by methods including phone, text message, and email; messages may be left on my answering machine or with a family member.

_____ _____

Signature of Patient, Parent/Guardian, or Personal Representative Date

_____ _____

Print name of person signing above Relationship to patient