Patient Registration

Today's Date:

Patient First Name | Patient Last Name | Patient M.I. | Preferred Name

Address

City | State | Zip Code

Home Phone | Work Phone

Cell Phone

Please check if you would not like to receive correspondence via:
☐ Text Message
☐ Email

Email Address

Gender
☐ Male ☐ Female

Marital Status
☐ Divorced ☐ Married ☐ Separated
☐ Single ☐ Widowed

Birth Date | Social Security Number | State ID/Driver License Number

Employment Status
☐ Full Time ☐ Part Time ☐ Retired ☐ N/A

Emergency Contact

Name | Phone

Student Status
☐ Full Time ☐ Part Time ☐ Not Applicable

Referral Source:

School Name (If Applicable)

Responsible Party (If someone other than the patient)

First Name | Last Name | M.I. | Preferred Name

Address

City | State | Zip Code

Home Phone | Work Phone

Cell Phone

Please check if you would not like to receive correspondence via:
☐ Text Message
☐ Email

Email Address

Gender
☐ Male ☐ Female

Marital Status
☐ Divorced ☐ Married ☐ Separated
☐ Single ☐ Widowed

Birth Date | Social Security Number | State ID/Driver License Number

Employment Status
☐ Full Time ☐ Part Time ☐ Retired ☐ N/A

Primary Insurance Information

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder/Subscriber/Sponsor Name | Birth Date | Social Security Number | Subscriber/Member ID Number

Employer Name

Employer Address

City | State | Zip Code

Insurance Company

Group Name

Group Number

Secondary Insurance Information (If Applicable)

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder/Subscriber/Sponsor Name | Birth Date | Social Security Number | Subscriber/Member ID Number

Employer Name

Employer Address

City | State | Zip Code

Insurance Company

Group Name

Group Number

Patient Medical History

Today's Date:

Patient First Name _____ Patient Last Name _____ Patient M.I. _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

_____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	Please list any other serious illness:
Convulsions ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No	_____
Cortisone Medicine ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No	_____

Additional Comments: _____

_____

I understand the importance of a truthful health history to assist the doctor in providing the best care possible and to the best of my knowledge, the above information is complete and correct. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform the dental office of any changes in my medical status. Should further information be needed, I grant permission to ask the respective health care provider or agency, to release such information to you.

_____ _____

Patient/Patient Guardian Signature Date

Office Policies & HIPAA Authorization

Today's Date:

Patient First Name _____ Patient Last Name _____ Patient M.I. _____ Birth Date _____

Thank you for choosing Westlake Family Dentistry as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care so that you may fully attain optimum oral health.
Everyone benefits when office and financial policy arrangements are understood. In order that you may have a definitive understanding of all office policies, please read the following and sign below.

Financial Policy
Patient's are financially responsible for all amounts due at the time that service is provided. We accept payment in the form of cash, personal check, certified check, money order, Visa, Mastercard, Discover, American Express and CareCredit. Returned checks will be subject to additional fees. We do not offer in-office financing/payment plans at this time. We will gladly provide a treatment cost estimate before your scheduled appointment at your request. Estimate is subject to change per your treatment plan changes.

Insurance Policy
Patients who carry dental insurance understand that as a courtesy, we will assist you in the processing of all insurance claims and will gladly file your dental claim for services rendered. We do require that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, at the time that we provide service to you. We must emphasize that this is only an estimate and all fees incurred are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient and the contract lies between the patient and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulatons and requests of your insurance company that may assist in the processing of your claim. Estimates are based on benefit information provided to us by your insurance company. This information does not constitute a guarantee of payment. For a more accurate estimate of costs, we recommend and typically submit pre-authorization to your insurance company prior to beginning service per your request. This is the most accurate and dependable way to determine benefits. Please be advised however that processing time is based on insurance company handling time. This can typically take anywhere from 3-6 weeks depending upon your insurance company. Once insurance has finalized payment, a statement will be sent to you for any remaining balance and will be due upon receipt. If youre insurance company has not made a payment withing 60 days of the date of service, the unpaid balance will become your responsibility and is subject to finance charges and the collection process. By signing below your hereby authorize and consent to the following:

- Use of your signature on all insurance claims
- Use and disclosure of health information to the insurance company I have listed and their agents by the doctor and staff for the purpose of obtaining payment for services rendered, determining insurance benefits or the benefit payable for related services.

Appointment Policy
Your appointment time is reserved for you per your request. If you are late for your appointment, we may not be able to accommodate you. If you think that you will be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you.
We maintain a very strict schedule and must insist that appointment times be maintained. Failure to attend your appointment at the scheduled appointment time is an inconvenience to not only the practice but to other patients who have reserved times which may be affected.
We require twenty-four (24) hour notice to cancel or reschedule an appointment reserved Monday through Friday. We require forty-eight (48) hour notice to cancel or reschedule an appointment reserved for a Saturday. An answer machine is available for messages left after business hours.
Neglect to provide the required notice of cancellation or failure to attend your appointment will result in penalty. A forty (40) dollar fee will be assessed to your account and the account will be documented. Three (3) missed appointments may result in dismissal from our practice as a patient.

Acknowledgement of Receipt of Notice of Privacy Practices
We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. By signing below, you acknowledge that you have read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosure of your health information. By signing below, you acknowledge that you understand that Westlake Family Dentistry has the right to change its Notice of Privacy Practices at any time and that you may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. It is understand that you may request that you restrict how your private information is to be used or disclosed to carry out treatment, payment or healthcare operations. By signing below, you authorize the release of your confidential protected dental information. I understand that this authorization is voluntary and that the information to be disclosed is protected by law.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies.

_____ _____
Patient/Patient Guardian Signature Date

Only to be completed if you wish to permit disclosure of protected health information to any person(s). You must authorize the release in writing.

Since a durable Power of Attorney for Health Care is only effective after you have lost your capacity to make or communicate decisions, the Power of Attorney does not authorize release of medical information to the person named while you remain competent. If you wish to permit disclosure of your protected health information, while you remain competent, you must compete and sign below.

Person Authorized to Receive the Disclosure: _____ _____
Name Relationship to Patient

☐ I hereby authorize the release of my complete protected health information.

☐ I hereby authorize the release of my complete protected health information with the exception of the following:

- ☐ Communicable Diseases
- ☐ Alcohol and/or Drug Abuse
- ☐ Other (Specify): _____

This authorization will:

☐ not expire

☐ expire on _____
Date

☐ upon the happening of the following event: _____

_____ _____
Patient/Patient Guardian Signature Date