PATIENT INFORMATION FORM

PATIENT

Name _____
Last First

Address _____ Apt.#____

City _____ Zip _____

How long at this address? _____

Phone_____ Cell _____

Email _____

Social Security #_____

Drivers License #_____

Age _____ Date of Birth _____

RESPONSIBLE PARTY (SKIP IF SAME AS ABOVE)

Name _____
Last First

Address _____ Apt.#____

City _____ Zip _____

How long at this address? _____

Relationship to patient _____

SSN#_____ Driver's Lic. # _____

Age _____ Date of Birth _____

EMPLOYMENT

Occupation _____

Employer _____

Length of Employment _____

Business Address _____

City _____ Zip _____

Business Phone_____ Ext. _____

EMERGENCY CONTACT

Name _____

Phone_____

HOW DID YOU HEAR ABOUT US?

☐ Family/friends	☐ Newspaper	☐ Radio
☐ Office sign	☐ Office transfer	☐ Yellow Pages
☐ Billboard	☐ Our website	☐ Direct mail
☐ Flyer/coupon	☐ Online search	☐ Online ad
☐ Insurance plan	☐ TV	

Do you have family or friends who may need dental care?
If so, please list name(s) and relationship(s):

Were you referred by anyone? _____

INSURANCE / DENTAL PLAN (PRIMARY)

Plan Name _____

Address _____

City _____ Zip _____

Insurance/Plan Phone#_____

Insured's Name_____

Union _____ Group#_____ Plan# _____

Insured SSN# _____ Date of Birth _____

INSURANCE / DENTAL PLAN (SECONDARY)

Plan Name _____

Address _____

City _____ Zip _____

Insurance/ Plan Phone #_____

Insured's Name_____

Union _____ Group#_____ Plan# _____

Insured SSN# _____ Date of Birth _____

1. I certify that the information provided is accurate and will be used to grant credit and provide dental services. I understand that I am financially responsible for all charges not covered by or paid by my insurance for any reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by this authorization. I authorize release of any information relating to any dental claim(s).
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

_____ _____
Signature of Patient or Responsible Party **Date**
(Parent if patient is a minor

(Please complete both sides)

HEALTH AND DENTAL HISTORY

WEST VISTA DENTAL

Date _____

Patient Name _____ Last _____ First

Date of Birth _____ Age _____

REASON FOR VISIT _____

Other _____

Do you have any health condition we should be aware of? ☐ Yes ☐ No _____

Date of last visit to a dentist _____ Treatment performed _____

Was the treatment completed? _____ When were dental x-rays taken? _____

Did you have a cleaning? ☐ Yes ☐ No

Have you had periodontal (gum) treatment? ☐ Yes ☐ No

Are you happy with your smile? ☐ Yes ☐ No

Do you have missing teeth? ☐ Yes ☐ No

Do your gums bleed after brushing/ flossing? ☐ Yes ☐ No

Do You wear dentures? ☐ Yes ☐ No

Are You happy with your dentures? ☐ Yes ☐ No

Do You Drink Alcoholic Beverages? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

PLEASE CHECK IF ANY OF THE FOLLOWING APPLY TO YOU:

☐ Problems with past dental treatment ☐ Bleeding after an extraction ☐ Teeth grinding ☐ jaw clinching

☐ Ear problems (including popping, locking, pain and clicking) ☐ Temporomandibular Joint Dysfunction (TMJ)

Description _____

MEDICAL INFORMATION

Are you under a doctor's care? ☐ Yes ☐ No If yes, please specify _____ Dr. Name _____ Phone _____

Are you allergic to penicillin, local anesthetics, tranquilizers, codeine or any other medicine? _____

Are you currently taking any medications (incl. Birth Control, Blood Thinners incl. Aspirin? (If yes, specify) _____

_____

Do you take Bisphosphinates? _____

Are you pregnant? If so, how many months? _____

Do you have any other health problems we should be aware of? _____

PLEASE CHECK IF YOU'VE HAD ANY OF THE FOLLOWING:

☐ Artificial heart valve	☐ Chemo/rad therapy	☐ Heart surgery	☐ Liver problems	☐ Sleep apnea
☐ AIDS/HIV	☐ Cosmetic surgery	☐ Heart problems	☐ Low blood pressure	☐ Smoking tobacco
☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Lung disease	☐ Stroke
☐ Angina	☐ Dizziness or fainting	☐ High blood pressure	☐ Pacemaker	☐ Thyroid problems
☐ Arthritis	☐ Drug addiction	☐ Jaundice	☐ Phen-fen	☐ TMD or TMJ
☐ Asthma	☐ Epilepsy	☐ Joint replacement	☐ Psychiatric care	☐ Tuberculosis
☐ Bleeding problems	☐ Glaucoma	☐ Kidney disease	☐ Rheumatic fever	☐ Venereal disease
☐ Cancer	☐ Heart attack	☐ Latex allergy	☐ Sinus trouble	☐ Sleep study

Doctor Comments _____

_____

I have answered every question completely and accurately to the best of my knowledge. I will inform my dentist of changes in my health and/or medication. I certify that I consent to taking x-rays and an oral examination.

Patient Signature or Responsible Party _____ **Date** _____ **Doctor Signature** _____

(Parent if patient is a minor)

MEDICAL UPDATE

Patient Signature _____ **Doctor Signature** _____ **Date** _____

Patient Signature _____ **Doctor Signature** _____ **Date** _____