WESTSIDE DENTAL GR

Thank you for trusting your dental health with us! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL) **DATE**______________

NAME________________________________ **BIRTHDATE**______________ **SS #**______________

ADDRESS________________________________ **CITY**______________ **STATE**______ **ZIP**__________

HOME PHONE ______________ CELL PHONE ______________ (Circle preferred phone) WORK PHONE______________

EMAIL______________________ Who may we thank for referring you?______________________

Person to contact in emergency______________________ **RELATIONSHIP**______________ **PHONE**______________

Check Appropriate Boxes Minor College Student Single Married Divorced Widowed Separated

Employer ______________________ Occupation ______________________

PARTY FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT (IF DIFFERENT THAN PATIENT)

NAME________________________________ **BIRTHDATE**______________ **SS #**______________

ADDRESS________________________________ **CITY**______________ **STATE**______ **ZIP**__________

HOME PHONE ______________ CELL PHONE ______________ (Circle preferred phone) WORK PHONE______________

EMAIL______________________ **RELATIONSHIP TO PATIENT**______________________

PRIMARY DENTAL INSURANCE (IF ANY)

SUBCRIBER NAME______________________ **RELATIONSHIP TO PATIENT**______________________

ADDRESS (if diff than patient)______________________ CITY______________ STATE______ ZIP__________

DOB______________ **SS #**______________ EMPLOYER______________________

INSURANCE CO______________________ **GROUP #**______________ **CONTRACT #**______________

INSURANCE CO ADDRESS______________________ INSURANCE PHONE______________

SECONDARY DENTAL INSURANCE (IF ANY)

SUBCRIBER NAME______________________ **RELATIONSHIP TO PATIENT**______________________

ADDRESS (if diff than patient)______________________ CITY______________ STATE______ ZIP__________

DOB______________ **SS #**______________ EMPLOYER______________________

INSURANCE CO______________________ **GROUP #**______________ **CONTRACT #**______________

INSURANCE CO ADDRESS______________________ INSURANCE PHONE______________

HEALTH HISTORY

Name ______________________ Birth Date________ Email______________________

Address____ Phone______________

Have you been hospitalized in the last 5 years? No Yes If yes, reason: ______________________

Are you currently receiving medical care? No Yes If yes, nature of care: ______________________

Please list all the names and specialties of the physicians who are currently providing you care:

____

Abnormal Bleeding from a cut	No	Yes	**Joint Replacement (How long ago?)**	No	Yes
Abnormal Heart Condition	No	Yes	Kidney Disease	No	Yes
Anemia	No	Yes	**Latex Allergy/Sensitivity**	No	Yes
Asthma	No	Yes	Liver Disease/Jaundice	No	Yes
Diabetes	No	Yes	Other Infection	No	Yes
Emphysema/Respiratory Illness	No	Yes	Previous Biopsies	No	Yes
Epilepsy/Prone to Seizures	No	Yes	Psychosis	No	Yes
Glaucoma	No	Yes	Recurrent Illnesses	No	Yes
Heart Condition(s) – Surgery, Disease, Attack	No	Yes	Rheumatic Fever	No	Yes
Heart Murmur (Mitral Valve Prolapse)	No	Yes	Slow Healing Mouth Sores	No	Yes
Hepatitis (What type?)	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
HIV Positive/AIDS Related Complex	No	Yes	Unintentional Weight Loss or Gain	No	Yes

Are you required to **Pre-Medicate** before dental treatment? **No** **Yes**

Do you have a history of abnormal blood pressure? **No** **Yes**
If yes, what is it usually?

Women:
Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Are you allergic or have you had a reaction to:
Local anesthetics .... No Yes
Penicillin or other antibiotics .... No Yes
Aspirin .... No Yes
Codeine, valium or other sedatives .... No Yes
Please list additional allergies:

Are you a smoker? If yes, how much per day? ______________ No Yes

Please list any medications you are currently taking: ______________________________________

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Are you happy with the appearance of your teeth and smile? No Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

______________________ ____________ ______________________________

Patient/Parent Signature **Date**

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