WestDental™
Put Your Health Where Your Mouth Is™

New Patient Registration Form

PATIENT INFORMATION			
Last name:	**First Name:**		**Middle Initial**:
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Other _____	**Social Security #:**	**Birth Date**:	**Sex**: ❑ M ❑ F
Street Address:	**City**:	**State/Zip Code**:	
Email address:			
Cell Phone:	**Home Phone**:	**Work Phone**: **Ext**:	
Primary Care Physician Name:	**Physician Address**:	**Physician Phone**:	
Employer Name:	**Employer Address**:	**Occupation**:	
Pharmacy Name:	**Pharmacy Address:**	**Pharmacy Phone:**	

I give **WestDental** consent to communicate with the following individual(s) about my healthcare Including but not limited to appointment details and treatment plans;

Name:	**Relationship to Patient:**

PARENT/ GUARDIAN INFORMATION (IF PATIENT IS A MINOR) ❑ Not Applicable	
Custodial Parent/ Guardian Name (s):	**Phone Number**:
Address:	
Custodial Parent/ Guardian Name (s):	**Phone Number**:
Address:	

CAREGIVER INFORMATION (IF APPLICABLE) ❑ Not Applicable

In the case that no parent/guardian can be reached, please allow the following named individual to consent to Dental Treatment for the above-named child in accordance with **WestDental** Policy:

1. Parent/Guardian must be present and consent for new Dental Treatment.
2. Caregiver may bring child in for pre-determined treatment discussed with parent and hygiene exam.
3. Unexpected treatment discovered when caregiver is present requires oral consent of the parent/guardian which office staff must obtain and record in chart.

Caregiver's Full Legal Name:	**Date of Birth**:
Address:	**Phone Number:**
Relationship to Child:	

Adult Health History Form

(Patient 18 and Over)

SKIP THIS PAGE FOR PEDIATRIC PATIENTS

Have you ever had any of the following? Please check those that apply:

- ❒ ADHD
- ❒ AIDS/HIV
- ❒ Allergies: _____
- ❒ Anemia
- ❒ Anxiety Disorder
- ❒ Arthritis
- ❒ Artificial Joints
- ❒ Asthma
- ❒ Autism
- ❒ Blood Disease
- ❒ Cancer
- ❒ Codeine Allergy
- ❒ Diabetes
- ❒ Developmental Disorder
- ❒ Dizziness
- ❒ Epilepsy
- ❒ Excessive Bleeding
- ❒ Fainting
- ❒ Facial Pain
- ❒ Glaucoma
- ❒ Growths
- ❒ Hay Fever
- ❒ Head Injuries
- ❒ Headaches
- ❒ Heart Disease
- ❒ Heart Murmur
- ❒ Hepatitis
- ❒ High Blood Pressure
- ❒ Jaundice
- ❒ Jaw Locking
- ❒ Jaw Pain
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Mental Disorders
- ❒ Nervous Disorders
- ❒ Pacemaker
- ❒ Penicillin Allergy
- ❒ Pregnancy
  Due Date:_____
- ❒ Radiation Treatment
- ❒ Respiratory Problems
- ❒ Rheumatism
- ❒ Sinus Problems
- ❒ Sleep Apnea
- ❒ Special Education
- ❒ Stomach Problems
- ❒ Stroke
- ❒ Snoring
- ❒ Tuberculosis
- ❒ Tumors
- ❒ Ulcers
- ❒ Venereal Disease
- ❒ Other:
  _____
  _____
  _____

Do you smoke?	❑ Yes ❑ No	If yes, how many per day:
Have you ever had any complications following dental treatment?	❑ Yes ❑ No	If yes, please explain:
Have you been admitted to a hospital or needed emergency care during the past two years?	❑ Yes ❑ No	If yes, please explain:
Are you now under the care of a physician?	❑ Yes ❑ No	If yes, please explain:
Do you have any health problems that need further clarification?	❑ Yes ❑ No	If yes, please explain:
Please list all medications and dosages you are currently taking:		

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform thedoctors at the next appointment without fail.

Patient/Guardian Name (Print):_____ Date: _____

Patient/Guardian Name (Signature):_____ Date: _____

Adult Medical Questionnaire

(Patients 18 and Over)

SKIP THIS PAGE FOR PEDIATRIC PATIENTS

At **WestDental**, we care about your overall health and well-being. It's well-documented that certain oral health problems are related to many chronic diseases and can affect how you eat, sleep and live.

Please complete this questionnaire so we can help you be your healthiest you.

Name:_____**Date**: _____

Please circle "yes" or "no" for each question:

Do you have high blood pressure or take blood pressure medication?	Yes No
Do you have diabetes or pre-diabetes?	Yes No
Have you ever experienced an irregular heart rhythm or been diagnosed with atrial fibrillation (aFib)?	Yes No
Have you ever had a stroke, transient ischemic attack (TIA), or heart attack?	Yes No
Do you often feel tired, fatigued, or sleepy during the daytime?	Yes No
Have you ever been told you snore?	Yes No
If yes, does your snoring bother anyone else?	Yes No
Have you ever woken yourself up gasping or with heart racing?	Yes No
Do you currently use a CPAP device while you sleep? If yes, do you sometimes skip a night or take it off while sleeping? Yes No	Yes No

Discussed with patient: _____ Yes _____ No

Hygienist Name: Initials _____ Signature _____

E0008: Sleep Questionnaire form

E0006: Refer for Sleep Study/Physician

E0000: Positive Sleep Questionnaire if 2 or more answers of yes

***Please enter code in Dentrix at time of visit

Pediatric Health History Form

(Patients Under 18)

SKIP THIS PAGE FOR ADULT PATIENTS

Child's Name: _____ Nickname: _____Date of Birth: _____
Address: _____ City: _____State:_____
Zip: _____
Home Phone: _____Cell Phone: _____ SS #: _____ Age: _____
Sex: ___ Male ___ Female Pronouns: _____

Parent #1: _____ Relationship to Patient: _____
Employer: _____ Work#: _____ Cell: _____
Email: _____Date of Birth: _____ SS#: _____

Parent #2: _____ Relationship to Patient: _____
Employer: _____ Work#: _____ Cell: _____
Email: _____Date of Birth: _____ SS#: _____

Have we seen other children in your family? _____

MEDICAL HISTORY

Child's Physician/ Pediatrician: _____ Phone: _____

____ Yes ____ No Is your child in good health? Date of last physical exam: _____
____ Yes ____ No Has your child ever had a health problem? _____
____ Yes ____ No Is your child allergic to anything? _____
____ Yes ____ No Are your child's immunizations/ vaccines up to date? If not, please explain:
_____
____ Yes ____ No Has your child had any surgeries/ hospitalizations? If yes, please explain: _____
_____
____ Yes ____ No Is your child currently taking any medications? Please give medications, dosage, and reason:
_____
____ Yes ____ No Has your child ever had a blood transfusion
____ Yes ____ No Does your child smoke or use tobacco products?
____ Yes ____ No Has your child previously seen a dentist?
Date last seen: _____ Name of Dentist: _____
____ Yes ____ No Has your child ever received fluoride in any form?
____ Yes ____ No Does your child suck his/her thumb or fingers?
____ Yes ____ No Are your child's teeth brushed once or more a day?
____ Yes ____ No At what age did your child stop bottle/breast feeding? _____

Please check any of the following which your child has been treated for:

❒ Aids	❒Cleft Lip/Palate	❒Heart Disease	❒Pregnant	❒Spinal Bifida
❒ ADHD	❒Congenital Birth Defects	❒Heart Murmur	❒Rheumatic Fever	❒Syndrome
❒ Anemia	❒ Diabetes	❒Hepatitis	❒Seasonal Allergies	❒Tonsils/Adenoid
❒ Asthma/Breathing	❒Endocrine/Growth	❒Kidney Disease	❒Seizures	❒Tuberculosis
❒ Autism	❒Eyesight	❒Latex Allergy	❒Shunt	
❒ Blood Dyscrasias	❒Food Allergies	❒Liver/GI Disease	❒Sickle Cell Disease	
❒ Cancer/Tumors	❒ Frequent Infections	❒Mental Delays	❒Snoring	
❒ Cerebral Palsy	❒Headaches	❒Personality/ Social	❒Speech/Hearing	

❒ Other: _____

____ Yes ____ No Does your child snore?

____ Yes ____ No Does your child wake up with headaches in the morning?

____ Yes ____ No Does your child seem sleepy during the day?

____ Yes ____ No Has your child ever woken gasping for air?

____ Yes ____ No Has anyone in your family been diagnosed with sleep apnea? If yes, what treatment was received? _____

Is there anything else we should know about your child?

_____

_____

Signature of Legal Guardian: _____ Relationship to Patient:_____

Date: _____

RESPONSIBLE PARTY INFORMATION				
The following is for: ❑ Patient ❑ Person Responsible for Payment ❑ Relationship to Patient _____				
Name:		**Sex**: ❑ M ❑ F	**Marital Status**: ❑ Single ❑ Married ❑ Divorced ❑ Other _____	
SS#:	**Birth Date**:	**Home Phone:**	**Work Phone:**	**Cell Phone:**
Street Address:		**City/State/Zip:**		

INSURANCE INFORMATION				
PRIMARY INSURANCE:				
Occupation:	**Employer**:	**Employer Address**:		**Employer Phone**:
Name of Primary Insurance:				
Subscriber's Name:		**Birth Date**:	**Group #**:	**ID #**:
Patient's Relationship to Subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other: _____			
SECONDARY INSURANCE:				
Occupation:	**Employer**:	**Employer Address**:		**Employer Phone**:
Name of Secondary Insurance:				
Subscriber's Name:		**Birth Date**:	**Group #**:	**ID #**:
Patient's Relationship to Subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other: _____			

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign all insurance benefits directly to **ProHEALTH Dental** that are otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the paymentsof benefits and authorize the use of this signature on all insurance submissions.

_____ _____

Patient/Guardian Name (Print): Date:

_____ _____

Patient/Guardian Name (Signature): Date:

Consent for Dental Treatment and Acknowledgement of Receipt of Information

State law requires our office to obtain your consent for your contemplated oral care and dental treatment. Please read this form carefully and ask about anything you do not understand. We will be pleased to further explain and discuss your concerns and questions.

I hereby authorize consent for oral and dental treatment that may include, but not limited to, the following: examination, radiographs (x-rays), diagnosis, dental prophylaxis (cleaning), fluoride treatment, restorations (i.e. fillings, pulpotomy, stainless steel crowns), anesthesia, oral surgery (extractions), interceptive orthodontic treatment and emergency treatment.

I understand that during any planned procedure, unforeseen conditions may arise that may necessitate treatment or procedures in addition to, or different from those originally discussed. In addition, although I am not advised that positive results are expected, the possibility and nature of complications cannot be accurately anticipated and, therefore, there can be no guarantee expressed or implied either as to the result of treatment.

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. These risks include, but are not limited to the following: nausea following anesthesia, numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of various materials (i.e. stainless-steel crowns), injury to the tongue, lips, cheeks, damage to possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. I further understand and accept that complication may require additional medical, dental or surgical treatment and may require hospitalization.

Integrated Health Screening Consent

WestDental provides a convenient, noninvasive chairside screening for critical clinical vital sign data thatmay reveal an undiagnosed medical condition. While this is not a definitive diagnosis of a particular health complication - it may indicate the need for further evaluation.
Screening includes routine blood pressure, blood oxygenation, diagnostic heart rhythm monitor reading and oral cancer screening and head & neck examination.

Understanding this Form

I hereby state that I have read and understand this consent form, that I have been given the opportunity to ask questions that I might have and that all questions have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions that may arise during the course of my treatment.

I further understand that I am free to withdraw my consent to treatment at any time, and that my consent will remain in effect until such time that I choose to withdraw it.

_____ _____

Patient/Guardian Name (Print): Date:

_____ _____

Patient/Guardian Name (Signature): Date:

Referral Information

Tell us how you learned about our practice.

Please choose one blue box and then select one of the choices within that box.

01	**Neighborhood:**	***Select one:***	Neighborhood • Saw Sign • Walk In
02	**Insurance Company:**		_____ *Company Name*
03	**Family / Friend:**		_____ *Name of Family Member or Friend*
04	**Online:**	***Select one:***	Internet Search • Social Media • Website
05	**Advertisement:**	***Select one:***	Flyer/Postcard • Magazine • Mailing • Newspaper Outdoor/Community • Television
06	**Event:**		_____ *Event Name*
07	**Dentist:**		_____ *Dentist Name*
08	**Employee:**	***Select one:***	Our Company • CareMount • Catholic Health • Mt. Sinai Optum • ProHEALTH • Riverside • WestMed
09	**Other:**		_____ *Description*
99	**Doctor / Medical Office:**	***Select one:***	CareMount • Catholic Health • Mt. Sinai Optum • ProHEALTH • Riverside • WestMed _____ *Doctors Name*

Financial Agreement

Our goal is to provide the highest quality of dental care possible as well as a positive patient experience. Please see our financial policy.

All accounts are due and payable at time of service.
If a procedure requires multiple appointments, payment may be paid with a minimum of two payments or based on the numberof appointments to complete treatment.

Payment Options:

- Cash
- Check
- Visa / MasterCard / Discover / AMEX
- The Lending Club / Care Credit

Patients with Insurance: The patient/guarantor is responsible for the **estimated** non-covered portion, procedures and/or deductibles at the time of the service. Due to insurance policy changes and/or necessary changes in treatment plans, the insurance coverage may vary from the estimated treatment calculation. I acknowledge this is an estimate only and that I, notthe insurance company, am ultimately responsible for payment in full for all services not covered for any reason by my insurance.

Parents not accompanying their child to an appointment must make **prior** arrangements for payment (cash, check or creditcard authorization). **Parents accompanying their children** are financially responsible for payment.

There is a processing charge for **non-sufficient funds** or returned checks.

As instruments, chairs and personnel are reserved exclusively for your appointment, there may be a fee charged for changed or broken appointment with less than 24 hours in advance.

_____ _____
Patient/Guardian Name (Print): Date:

_____ _____
Patient/Guardian Name (Signature): Date:

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the *Health Insurance Portability & Accountability Act of 1996* ***(HIPAA)***. I understand that this information can and *will* be used to:

- Provide and coordinate my treatment among many health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient/Guardian Name (Print): Date:

_____ _____

Patient/Guardian Name (Signature): Date: