WEST LAKE HILLS
DENTAL

Date _____

1. **Patient's Name** _____ Driver's License # _____
   Last First Middle
2. Address _____
   Street City State Zip Code
3. Home Phone _____ Birth Date _____ Social Security # _____
4. E-mail Address _____ Mobile Phone _____ Work Phone _____

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5. **Person Responsible for Payment** _____
   Last First Middle
6. Address _____
   Street City State Zip Code
7. Relationship to Patient _____
8. Social Security # _____
9. Birth Date _____
10. Driver's License # _____
11. Home Phone _____
12. Employer _____
13. Work Phone _____

If minor, list parent's names:

Father _____
First Last

Mother _____
First Last

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14. **Patient's Spouse Name** _____
    Last First Middle
15. Spouse's Employer _____
16. Occupation _____
17. Work Phone _____

DENTAL INSURANCE INFORMATION (need copy of card)

18. Insured's Name _____
19. Insured's Birth Date _____
20. Insured's Address (if different from above) _____
21. Insured's Social Security # _____
22. Insured's Employer _____
23. Insurance Company Name _____ Group Name _____
24. Insurance Address _____

EMERGENCY INFORMATION

25. Local Friend or Relative not living with you _____
26. Complete Address _____
27. Phone Number _____

GETTING TO KNOW YOU

28. Why did you select our office? _____
29. Whom may we thank for referring you? _____
30. Is another member of your family or relative a patient in our practice? _____

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistants as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

PRIVACY POLICY

I have chosen NOT to receive a copy of the privacy policy. I understand a copy is available at any time.

_____

Patient's, Parent's or Guardian's Signature **Date**

DENTAL HISTORY

How would you rate the condition of your mouth? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ___/___/___ Date of most recent x-rays ___/___/_____
Date of most recent treatment (other than cleaning) ___/___/_____
I routinely see my dentist every: ❑ 3 mo. ❑ 4 mo. ❑ 6 mo. ❑ 12 mo. ❑ not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? Scale of 1 (least) to 10 (most): _____	❑	❑
2. Have you ever had an unfavorable dental experience?	❑	❑
3. Have you ever had complications from past dental treatment?	❑	❑
4. Have you ever had trouble getting numb or reactions to local anesthetic?	❑	❑
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	❑	❑
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	❑	❑
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?	❑	❑
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	❑	❑
9. Have you ever noticed an unpleasant taste or odor in your mouth?	❑	❑
10. Is there anyone with a history of periodontal disease in your family?	❑	❑
11. Have you ever experienced gum recession?	❑	❑
12. Are your teeth becoming loose on their own (without an injury), or do you have difficulty eating an apple?	❑	❑
13. Have you ever experienced a burning sensation in your mouth?	❑	❑
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	❑	❑
15. Does the amount of saliva in your mouth ever feel too little or do you have difficulty swallowing any food?	❑	❑
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	❑	❑
17. Are any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth?	❑	❑
18. Do you have grooves or notches on your teeth near the gum line?	❑	❑
19. Have you ever broken teeth, chipped teeth or had a toothache or cracked filling?	❑	❑
20. Do you frequently get food caught between any teeth?	❑	❑
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, or popping)	❑	❑
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	❑	❑
23. Do you / would you have any problems with chewing bagels, baguettes, protein bars or other hard food?	❑	❑
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn)or has your bite changed?	❑	❑
25. Are your teeth becoming more crooked, crowded, or overlapped?	❑	❑
26. Are your teeth developing spaces or becoming more loose?	❑	❑
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	❑	❑
28. Do you place your tongue between your teeth or close your teeth against your tongue?	❑	❑
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	❑	❑
30. Do you clench or grind your teeth together in the daytime or make them sore?	❑	❑
31. Do you have any problems with sleep or wake up with an awareness of your teeth?	❑	❑
32. Do you wear or have you ever worn a bite appliance?	❑	❑
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your teeth that you would like to change?	❑	❑
34. Have you ever whitened (bleached) your teeth?	❑	❑
35. Have you ever felt uncomfortable or self-conscious about the appearance of your teeth?	❑	❑
36. Have you been disappointed with the appearance of previous dental work?	❑	❑

Patient's Signature _____ **Date** _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Preferred Name _____ Age_____

Name of Physician/and their specialty _____

Most recent physical examination_____ Purpose _____

What is your estimate of your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury	❑	❑
2. allergic reaction to		
❑ aspirin, ibuprofen, acetaminophen		
❑ penicillin		
❑ erythromycin		
❑ codeine		
❑ local anesthetic		
❑ fluoride		
❑ metals (gold, stainless steel)		
❑ latex		
❑ any other medications_____		
3. heart problems or cardiac stent within last 6 months	❑	❑
4. history of infective endocarditis	❑	❑
5. artificial heart valve, repaired heart defect (PFO)	❑	❑
6. pacemaker or implantable defibrillator	❑	❑
7. orthopedic implant (joint replacement)	❑	❑
8. rheumatic or scarlet fever	❑	❑
9. high or low blood pressure	❑	❑
10. a stroke (taking blood thinners)	❑	❑
11. anemia or other blood disorder	❑	❑
12. prolonged bleeding due to a slight cut (INR>3.5)	❑	❑
13. emphysema, sarcoidosis	❑	❑
14. tuberculosis, measles, chicken pox	❑	❑
15. asthma	❑	❑
16. breathing or sleep problems (i.e. snoring, sinus)	❑	❑
17. kidney disease	❑	❑
18. liver disease	❑	❑
19. jaundice	❑	❑
20. thyroid, parathyroid disease, or calcium deficiency	❑	❑
21. hormone deficiency	❑	❑
22. high cholesterol or taking statin drugs	❑	❑
23. diabetes (HbA1c=_____)	❑	❑
24. stomach or duodenal ulcer	❑	❑
25. digestive disorders (i.e. gastric reflux)	❑	❑

	YES	NO
26. osteoporosis/osteopenia (taking bisphosphonates)	❑	❑
27. arthritis	❑	❑
28. glaucoma	❑	❑
29. contact lenses	❑	❑
30. head or neck injuries	❑	❑
31. epilepsy, convulsions (seizures)	❑	❑
32. neurological problems (attention deficit disorder)	❑	❑
33. viral infections and cold sores	❑	❑
34. any lumps or swelling in the mouth	❑	❑
35. hives, skin rash, hay fever	❑	❑
36. STD / HPV / STI	❑	❑
37. hepatitis (type___)	❑	❑
38. HIV / AIDS	❑	❑
39. tumor, abnormal growth	❑	❑
40. radiation therapy	❑	❑
41. chemotherapy	❑	❑
42. emotional problems	❑	❑
43. psychiatric treatment	❑	❑
44. antidepressant medication	❑	❑
45. alcohol / drug dependency	❑	❑
ARE YOU:		
46. presently being treated for any other illness	❑	❑
47. aware of any change in your general health	❑	❑
48. taking medication for weight management	❑	❑
49. taking dietary supplements	❑	❑
50. often exhausted or fatigued	❑	❑
51. experiencing frequent headaches	❑	❑
52. a smoker or smoked previously	❑	❑
53. considered a touchy / sensitive person	❑	❑
54. often unhappy or depressed	❑	❑
55. easily upset or irritated	❑	❑
56. FEMALE: taking birth control pills	❑	❑
57. FEMALE: pregnant	❑	❑
58. MALE: prostate disorders	❑	❑

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List any medications, supplements, and or vitamins taken within the last two years

DRUG	PURPOSE	DRUG	PURPOSE

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ **Date** _____

Doctor's Signature _____ Date _____

Our Financial Policy

Thank you for choosing us as your dental health care provider. We appreciate your trust in us and look forward to helping you with your dental care.

All payments are due at the time of service. We accept Cash, Personal checks, credit card, or debit card for payment.

For all patients with dental insurance, we are happy to process your insurance claim for your reimbursement as long as we have complete insurance information. We will work diligently to obtain payment from your insurance company. Please keep in mind your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company. All charges are your responsibility whether your insurance company pays or not. Please be aware that not all services are covered benefits in all dental contracts. You are responsible for the knowledge of coverage of your dental policy. We ask that you familiarize yourself with your policy and be aware of any limitations that might exist.

Please note that if you are given a financial estimate of your services prior to service being rendered that is ONLY AN ESTIMATE of charges. It is possible that your dental insurance may pay less than or more than was estimated. If your insurance company does not pay toward your claim within 45 days of date of service, we will require you pay the balance due. In the event that your insurance pays us after that time, you will be reimbursed.

_____ _____

Signature Date