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Westmoreland
FAMILY DENTISTRY

Patient Information

First Name _____ Middle _____ Last Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Email Address _____
Date of Birth ___/___/___ SSN _____-_____-_____ Gender _____ Marital Status _____
Employer _____ Work Phone _____

We are glad you chose Westmoreland Family Dentistry for your dental needs.
How did you hear about us? (check one)

☐ Insurance ☐ Drive By ☐ Website ☐ Online ☐ Social Media
☐ Family Member: _____ ☐ Friend: _____

Emergency Contact

Name _____ Phone Number _____ Relationship_____

Insurance Information

Subscriber Name _____ Relationship to Subscriber_____
Subscriber's Employer _____ Policy Holder Date of Birth____/____/____
Policy Holder SSN _____-___-_____ Dental Insurance Company_____
Member ID #_____ Group #_____

Please give a copy of your driver's license and dental insurance card to front office staff. If you have any changes in your insurance, let our office know at least 2 days before your scheduled appointment.

Canceled/ Missed Appointment Policy

Please be courteous and call the office immediately if you are unable to keep your scheduled appointment time. **Patients who miss or cancel a scheduled appointment with less than 24 business hours notice will be required to pay a $50 fee in order to reschedule the appointment**. Patients who arrive 10 minutes late to their scheduled appointment time may be asked to reschedule as a courtesy to the next scheduled patient. I have read and understand these terms.

_____ _____
Signature of Patient (or Guardian) Date

Name:_____

Medical History

Although dental personnel primarily treat your mouth, your mouth is part of your entire body. Your health history and medications that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you taking any medications? ☐ Yes ☐ No
If yes, list all medications you are currently taking. _____
_____
_____
Are you prescribed any medications you are not currently taking? ☐ Yes ☐ No
If yes, list all medications you are prescribed but are not currently taking. _____
_____
Do you have a condition requiring antibiotic premedication? ☐ Yes ☐ No
Are you under a physician's care? ☐ Yes ☐ No
Do you take a blood thinner? ☐ Yes ☐ No
If yes, specify.
☐ Warfarin ☐ Clopidogrel ☐ Xarelto ☐ Effient
☐ Pradaxa ☐ Aspirin ☐ other: _____
Do you use bisphosphonates? ☐ Yes ☐ No
If yes, specify.
☐ Actonel ☐ Aredia ☐ Boniva ☐ Fosamax ☐ Prolia
☐ Reclast ☐ Xgeva ☐ Zometa ☐ other: _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
If yes, specify._____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No
Are you diabetic? ☐ Yes ☐ No
If yes, specify. ☐ Type 1 ☐ Type 2 Most recent HbA1c:_____
Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ other: _____
Do you have any dental anxiety or phobias? ☐ Yes ☐ No
If yes, please explain _____
When was your last dental cleaning? _____
Is there anything you would like to change about your smile? _____
Has anyone ever heard you snore? ☐ Yes ☐ No
Has anyone ever witnessed you stop breathing in your sleep? ☐ Yes ☐ No
Do you own a CPAP? ☐ Yes ☐ No

Women Only- Check if anything of the following apply.
☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Name:_____

Medical History Continued

Do you have or have you ever had any of the following medical conditions?

AIDS/HIV Positive	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Alzheimer's	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No
Herpes	☐ Yes ☐ No	Angina	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No
Excessive Bleeding	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Blood Transfusion	☐ Yes ☐ No
Stomach/Intestinal Disease	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No
Swelling of Limbs	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Seasonal Allergies	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Heart Attack/ Failure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Heart Pacemaker	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Anemia	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
Epilepsy or Seizures	☐ Yes ☐ No	Artificial Heart Valve	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Fainting Spells/Dizziness	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Spina Bifida	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Chest Pains	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Cold Sores/Fever Blisters	☐ Yes ☐ No
Pain in Jaw Joints	☐ Yes ☐ No	Congenital Heart Disorder	☐ Yes ☐ No
Parathyroid Disease	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes, please explain _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

_____ _____

Signature of Patient (or Guardian) Date

HIPAA Privacy Practices Consent

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment, or health care operations. By signing this form, you consent to the use and disclosure of your protected health information for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures previously made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that: Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has Notice of Privacy Practices and the patient has the opportunity to review this Notice. The practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.
For more information see: https://www.hhs.gov/hipaa/for-individuals/index.html

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it at your request.
- We will never share any treatment records without your permission.
- No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore the same day of service payment in full for any services will be required.

_____ _____
Signature of Patient (or Guardian) Date

_____
Printed Name of Patient (or Guardian)

Privacy Authorization

I, _____,
Printed Name of Patient (or Guardian)

- ❏ would like _____ to have access to my dental records, who is my _____.
  Name Relationship
- ❏ do not want anyone to have access to my dental records.

Dental Insurance

Your cooperation in providing accurate insurance information is necessary to assist us in receiving prompt reimbursement. If your insurance company has not paid an outstanding portion of your bill within 30 days, you are expected to pay the balance in full at that time. Please know that as dental providers, our relationship is with you, not your insurance company. We will file insurance claims as a courtesy to our patients to one insurance company. If you have any changes to your dental insurance information, it is your responsibility to provide us with this information at least two days prior to your scheduled appointment. We will do our best to obtain accurate dental treatment benefits and history information from your insurance company. We request that you provide a copy of your Plan Benefit Document. As healthcare professionals, we recommend treatment based on patient needs, not on whether the procedure is fully or partially covered by insurance. By signing below, you agree to assign benefits for treatment and agree to pay for any services not covered by your dental insurance to Westmoreland Family Dentistry .

_____ _____
Signature of Patient (or Guardian) Date