We want to get to know you!

DENTISTRY AT WESTLAND
Patient Information

Today's date: ___ / ___ / ___

Name: _____ ☐ Female ☐ Male

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Bus. phone: _____ Marital status: ☐ Single ☐ Married ☐ Widowed

Birth date: _____/_____/_____ Social Security#: _____

E-mail address: _____ Name of spouse: _____

How do you enjoy spending your free time? _____

Who can we thank for referring you? _____

EMERGENCY INFORMATION

Person to contact: _____ Phone: _____

Relationship: _____

INSURANCE INFORMATION

Primary Insurance company name: _____ Is Insured a Patient? ☐ yes ☐ no

Insurance Plan Address: _____

Group#: _____ ID/Social Security#: _____

Insured's Address: _____ City: _____ State: ____ Zip: _____

Insured's birth date: ___ / ___ / ___

Insured's Employer: _____ Address: _____ City/St/Zip: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance company name: _____ Is Insured a Patient? ☐ yes ☐ no

Insurance Plan Address: _____

Group#: _____ ID/Social Security#: _____

Insured's Address: _____ City: _____ State: ____ Zip: _____

Insured's birth date: ___ / ___ / ___

Insured's Employer: _____ Address: _____ City/St/Zip: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Dentistry at Westland, LLC. Initials: _____

DENTAL HISTORY

What is the main reason for your visit today?

- ☐ Tooth pain
- ☐ Need a check-up
- ☐ Cleaning
- ☐ Orthodontics (braces)
- ☐ Whitening
- ☐ Cosmetic dentistry
- ☐ Sedation dentistry
- ☐ Other

Have you ever been treated for TMJ? ☐ yes ☐ no

Have you ever or do you suffer from headaches? ☐ yes ☐ no

Tension headaches? ☐ yes ☐ no

Migraine headaches? ☐ yes ☐ no

Muscle tenderness in jaw/teeth? ☐ yes ☐ no

MY HYGIENE

Date of your last hygiene visit? / / Interested in having regular hygiene cleanings? ☐ yes ☐ no

Have you ever had gum treatment? ☐ yes ☐ no Do your gums bleed? ☐ yes ☐ no

How many times a day do you brush? _____ floss? _____ Type of bristles? ☐ Soft ☐ Medium ☐ Hard

My Dental Health

On a scale of 1 to 5 (1 low/poor, 5 high/good) please rate:

My overall dental health is ..... ☐1 ☐2 ☐3 ☐4 ☑5

My committment to keeping my teeth is ..... ☐1 ☐2 ☐3 ☐4 ☑5

My sensitivity to dental procedures is ..... ☐1 ☐2 ☐3 ☐4 ☐5

My feeling toward my smile and the appearance of my teeth ..... ☐1 ☐2 ☐3 ☐4 ☐5

My level of confidence in my smile in social and professional situations ..... ☐1 ☐2 ☐3 ☐4 ☑5

My desire to have whiter teeth ..... ☐1 ☐2 ☐3 ☐4 ☐5

My interest in staightening crooked teeth ..... ☐1 ☐2 ☐3 ☐4 ☐5

My desire to remove any *silver mercury* filling from my teeth ..... ☐1 ☐2 ☐3 ☐4 ☐5

I would like to learn more about:

- ☐ Orthodontics
- ☐ Whitening
- ☐ Cosmetic dentistry
- ☐ Sedation dentistry
- ☐ Implants
- ☐ Bridges
- ☐ Veneers
- ☐ Dentures
- ☐ Other

MEDICAL HISTORY

Name of personal physician: _____

Address: _____

Phone number: _____

Approximate date of last visit: _____

Current health condition: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any serious health problems in the last five years? ☐ yes ☐ no If yes, please explain:

(For women) Are you currently pregnant? ☐ yes ☐ no If yes, how many months?

Please list prescription medications:

Please list vitamin/herbal supplements?

Please check if you are allergic to any of the following:

☐ Local anesthetics	☐ Sulfa drugs	☐ Latex sensitivity
☐ Penicillin/other antibiotics	☐ Aspirin	☐ Other _____
☐ Barbiturates or sedatives	☐ Codeine/other narcotics	

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chemotherapy	☐ Glaucoma	☐ Osteoporosis
☐ Alzheimer's Disease	☐ Chest Pains	☐ Heart Attack/Failure	☐ Pain in Jaw Joints
☐ Anaphylaxis	☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Psychiatric Care
☐ Arthritis/Gout	☐ Congenital Heart Disorder	☐ Heart Pace Maker	☐ Radiation Treatments
☐ Artificial Heart Valve	☐ Diabetes	☐ Hepatitis A	☐ Sinus Trouble
☐ Artificial Joint	☐ Drug Addiction	☐ Hepatitis B or C	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Epilepsy or Seizures	☐ High Blood Pressure	☐ Stroke
☐ Blood Disease	☐ Excessive Bleeding	☐ Irregular Heartbeat	☐ Swelling of Limbs
☐ Breathing Problem	☐ Excessive Thirst	☐ Leukemia	☐ Tuberculosis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ Liver Disease	☐ Tumors or Growths
☐ Cancer	☐ Frequent Headaches	☐ Mitral Valve Prolapse	☐ Ulcers

Have you ever had any serious illness not listed above? If yes, please explain: _____

APPOINTMENT CANCELLATION POLICY

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, we kindly request that you contact us by phone with advanced notice of two business days. We understand that conflicts arise; however failing your appointment or canceling without adequate notice more than once will result in a $50 charge and then discontinuation of services. Initials: _____

Signature _____ *Date* _____

Financial Policy & Patient Responsibility

Thank you for choosing Dentistry at Westland for your dental needs. Our goal is to provide you with the highest quality and most comprehensive dental care possible. Payment of dental services is the responsibility of the patient in the patient-dentist relationship. Therefore, we would like to explain our payment policy and patient responsibility expectations to you to ensure understanding and compliance.

Payment & Payment Options

**Payment for dental services is due at the time of service
**We accept Cash, Check, Visa, MasterCard, Discover or American Express
**A bank charge of $25.00 for returned checks due to non-sufficient funds

We believe it is your responsibility to complete treatment and follow a recommended dental maintenance schedule. If treatment plans are not followed and appointments are missed, adverse results could affect your dental health. If you do not proceed with your treatment plan in a timely manner, further treatments for the involved teeth etc. can be affected.
_____ (Initials) I understand the above information

Insurance Policy

Dr. Chad Fine provides many types of dental services within his practice. Many insurance carriers have their own specific criteria set for how frequently an exam or procedure etc. can be performed in addition to not paying for certain types of services due to frequency, waiting periods or insurance plan guidelines. Consequently, it is impossible for us to know all of the many different employer group benefits from one employer to the next. Therefore, Dr. Chad Fine or his staff will not be held responsible for informing the patient whether a particular service is covered or not. Our staff will submit all necessary claims to your insurance carrier and provide any necessary information to assist in the payment of your claims. We ask that you carefully review your policy and/or contact your insurance carrier so you are aware of benefits, frequencies, limitations, and/or restrictions. You are responsible for any charges not covered by your insurance carrier. Insurance co-payments, coinsurance, deductibles, and non-covered services are to be paid at the time of service. Please be aware that your dental insurance has a yearly maximum and any charges over that amount will be your responsibility. We are providing the highest quality of dental care for you and your family regardless of insurance frequencies, limitations and/or restrictions. It is your responsibility to provide us with any changes regarding your insurance carrier.
_____(Initials) I understand the above information

Financial Responsibility

I further agree to pay all finance charges, collection cost, attorneys fees, and any other cost that may be incurred to enforce collection of any amount outstanding.
By signing below, I acknowledge and understand the Financial Policy of Dentistry at Westland, LLC and accept all payment terms under this Policy as well as my financial responsibilities as a patient at Dentistry at Westland.

_____ _____
Signature of Patient or Person Responsible for Account Date