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