

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

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

My Dental Health

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

My commitment 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 straightening 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:

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Bridges |
| <input type="checkbox"/> Whitening | <input type="checkbox"/> Veneers |
| <input type="checkbox"/> Cosmetic dentistry | <input type="checkbox"/> Dentures |
| <input type="checkbox"/> Sedation dentistry | <input type="checkbox"/> Other |
| <input type="checkbox"/> Implants | |

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 problem 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 allergica to any of the following :

- | | | |
|---|--|--|
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Latex sensitivity |
| <input type="checkbox"/> Penicillin/other antibiotics | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Barbiturates or sedatives | <input type="checkbox"/> Codeine/other narcotics | |

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

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

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

APPOINTEMT 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 falling your appointment or cancelling without adequate notice more than once will result in a \$75 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 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 allowed 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 and 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/ 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 of 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.

_____ (Initial's) 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

Dentistry at Westland

Appointment Cancellation Policy

Our Policy is as Follows:

We require that you give our office 48 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of \$75.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be released/transferred without the payment of this fee.

Additionally if a patient is more than 20 minutes late without prior notice for a scheduled appointment we will consider this a missed appointment and the \$75.00 cancellation fee will be charged.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice

Signature of patient

Date

print name), authorize Dentistry at Westland to debit my credit card for the \$75.00 fee for the Appointment Cancellation Policy.

I, _____(print name), authorize Dentistry at Westland to debit my credit card for the \$75.00 fee for the Appointment Cancellation Policy.

Credit Card Number/Type

CVC

Expiration Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private 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 also understand 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 Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below

Date:	Initials:	Reason:
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