Patient Information

Please Print

Circle One: Dr/Mr/Mrs/Ms/Miss

First: _____ Middle: _____ Last: _____Jr/Sr: _____

Street: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____

Email Address: _____ May we contact you by email? (circle) Yes No

Patient Social Security Number: _____ Patient Date of Birth: _____ Sex: (circle) M F

Emergency Contact: _____ Phone: _____

Preferred Pharmacy_____

How did you hear about us? ☐ Flyer ☐ Social Media ☐ Referral ☐ Other: _____

Insurance Information

Do you have Dental Insurance? (circle) Yes No Do you have Secondary Dental Insurance? (circle) Yes No

Primary Insured		Secondary Insured	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name		Employer Name	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance ID #		Insurance ID #	
Insurance Phone #		Insurance Phone #	

Authorization for Release of Health Records to External Parties

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _____

Relationship to the Patient: _____

I give authorization to disclose the following information:

- ☐ All treatment information
- ☐ Information specifically related to these treatment dates

Starting Date: _____ End Date: _____

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying Westcliff Family Dentistry in writing.

Signature of Patient (or Patient Representative) _____ Date: _____

Printed Name of Patient (or Patient Representative) _____

Health Information

We take your oral health very seriously. But before we start your treatment, we need some brief information on your medical history which may affect your treatment. All information is confidential.

Patient's Name: _____ Date of Birth: _____
Physician's Name & Phone #: _____
Reason for today's visit? _____
Are you interested in teeth whitening? (circle) **Yes No**
How would you rate your teeth on a scale of 1 to 10 (1 being the worst, 10 being the best)? _____
Have you ever been treated for periodontal (gum) disease? (circle) **Yes No**
Ever had Novocaine or another local anesthetic? (circle) **Yes No**
If wearing dentures, age of dentures: _____Are you interested in new dentures? (circle) **Yes No**
Are you taking or have taken Oral Bisphosphonates? (e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, (e.g., ZOMETA, AREDIA) (circle) **Yes No** Taken for how long? _____
Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes No**

Women patients only:

Is there a possibility of pregnancy? Yes No
Estimated delivery date: _____/____/____
Are you nursing? Yes No
Are you taking any birth control prescriptions? Yes No

- **List any CURRENT medications you are taking, including non-prescription drugs and herbals/vitamins. Please use the back to write further medications if needed:**

  1. _____ 2. _____ 3. _____ 4. _____

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Use of Tobacco Products			Alcoholism		
Heart Murmur			Allergies or Hives			Thyroid Disease			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Epilepsy or Seizures			Mouth sores/growths		
Diabetes			Teeth Grinding/Clenching			Fainting or Dizzy Spells			Aspirin/Anticoagulant Therapy		
Venereal Disease			Arthritis			Pace Maker/Heart Surgery			Ulcers or Stomach Problems		
High Blood Pressure			HIV Positive/AIDS			Pain in your jaw (TMJ)			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Latex Allergy			Cancer (Type:)		
Any type of Transplant			Heart Problem ( )			Sinus Problems			Any Artificial Hip, Knee or other Joint		
Drug Addiction			Dialysis			Excessive Bleeding			Other Disease or Illness:		
Hepatitis (Type:)			Chemotherapy			Stroke					
Liver Disease			Radiation Treatment			Kidney Disease					

- **List any medications you are ALLERGIC to. Please use the back to write further allergies if needed:**

  1. _____ 2. _____ 3. _____ 4. _____

Patient's Signature_____ Date_____