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:

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_____

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 817-759-9805.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. *Westcliff Family Dentistry* does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Westcliff Family Dentistry maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with *Westcliff Family Dentistry*.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. *Westcliff Family Dentistry* occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement: I have reviewed Westcliff Family Dentistry Privacy Policy.

Patient's Name (please print): _____ Date: _____

Patient Signature: _____ Date: _____

CANCELLATION AND BROKEN APPOINTMENT POLICY

A reserved appointment time in any dental office is limited and valuable. It is extremely important that all our patients honor their reserved dental appointments.

Those who fail to keep their scheduled appointments should not penalize the Dentist, our staff, and mainly our other patients. Our dental policy stipulates that failure to give sufficient notice to keep a scheduled appointment will result in a fee being charged. That charge is in accordance with our dental office's broken appointment policy for all of our patients. The patient is responsible for the payment of the charge.

- Cancellation, rescheduling, or failure to show-up for a scheduled appointment with less than 48 hours' notice will be charged the following:

$75 FOR ALL APPOINTMENTS

After a third missed or canceled appointment without 48-hour notice, the patient may be dismissed from the practice at our discretion.

Every effort is made to contact patients to confirm. Our staff will contact you 2 days prior to your scheduled appointment to confirm with you. Please understand that this is a courtesy call, text, or email. If we are unable to reach you, your appointment card will serve as your confirmation of the appointment and implies your obligation to be present.

FINANCIAL POLICY

We accept cash, checks, Care Credit, and all major credit cards (Visa, MasterCard, American Express, Discover). Payment for dental service is expected and required at the time of service, unless other arrangements have been made. Payment plans will require a credit card on file and will not exceed 6 months. Treatment appointments made will require a $50 down payment prior to treatment.

If qualified, there will be a 10% discount given to patients who choose to pre-pay in full for treatment rendered. Please inquire with office staff.

Although we do accept the assignment of most insurance companies, your insurance is an agreement between you and your insurance company. We will do our best to see that you receive your full benefits.

Patient's Signature: _____ **Date:** _____

Parent/Guardian (if patient is a minor): _____ **Relationship to Patient:** _____