Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

Westwood Dental ~ 4527 Rainbow Blvd ~ Kansas City, Kansas 66103 ~ 913-432-0765

PATIENT INFORMATION

Name_____( )Dr. ( )Mr. ( )Mrs. ( )Rev. ( )Other:_____
First MI Last

Address_____ Occupation_____ ( )Male ( )Female

City_____ State_____ ZipCode_____ Hm#(___)_____

Employer_____ Wk#(___)_____Ext____

Are you: ( )Minor ( )Single ( )Married ( )Divorced ( )Separated ( )Widowed Cell#(___)_____
Is Patient a full time student? ( ) No ( ) Yes: Name of School:_____

DOB:___/___/_____ SSN#_____ E-mail_____@_____

Spouse's Name_____ Spouse's Occupation_____
First MI Last

Spouse's Wk#_____Ext_____

Whom may we thank for referring you to our office?

RESPONSIBLE PARTY(if different than patient)

Name_____ Address_____
First MI Last

City_____ State_____ Zip_____ Cell#(___)_____

DOB:___/___/_____ SSN#_____ Relationship to Patient_____

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name_____ Relationship to patient:_____
DOB:___/___/____ Subscriber's SSN#_____ Group#_____
Insurance Company_____ PolicyID#_____

DENTAL INSURANCE:

Subscriber's Name_____ Relationship to patient:_____
Subscriber's Address_____ City_____State_____Zip_____
DOB:___/___/____ Subscriber's SSN#_____ Group#_____
Insurance Company_____ PolicyID#_____

DO *YOU HAVE ADDITIONAL DENTAL INSURANCE? ( ) Yes ( ) No If yes. Please complete the following:*

Subscriber's Name_____ Relationship to patient:_____
Subscriber's Address_____ City_____State_____Zip_____
DOB:___/___/____ Subscriber's SSN#_____ Group#_____
Insurance Company_____ PolicyID#_____

Westwood Dental
4527 Rainbow Blvd
Kansas City, KS

Medical History and Consent

(Please check all that apply)

Allergies

Acrylics	Y	N
Anaphalaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Other	Y	N

List other known allergies:

_____

_____

_____

Cardiovascular

- □Artificial Heart Valve
- □Coronary Artery
- □Chest Pain/Angina
- □Congestive Heart Failure
- □Heart Attack
- □Heart Murmur
- □High Blood Pressure
- □High Cholesterol
- □Irregular Heart Beat
- □Low Blood Pressure
- □Mitral Valve Prolapse
- □Pacemaker
- □Tachycardia

Endocrine

- □Diabetes
- □Gout
- □Hormonal Change
- □Thyroid Problems

Eyes,Ears,Nose& Throat

- □Changes in Hearing
- □Change in Vision
- □Dysphagia
- □Ear pain
- □Glaucoma
- □Hay Fever
- □Nasal Obstruction
- □Nose Bleeding
- □Sinus Problems
- □Tonsillectomy
- □Tinnitus

Gastrointestinal

- □Acid Reflux
- □GERD
- □Soft or Special Diet
- □Ulcers

Genitourinary

- □Frequent Urination
- □Kidney Disease
- □Nocturia

General

Current Weight:_____lbs
Height:_____ft_____in

- □Cancer
- □Fatigue/Tired
- □General Weakness
- □Headaches
- □HIV/AIDS
- □Knee/Hip Replacement
- □Liver Problems
- □Recent Trauma or Injury
- □Rheumatic Fever
- □Radiation Treatment
- □Weight Change

Hematological

- □Bleeding Problems
- □Hepatitis

Oral

- □Bleeding Gums
- □Dry Mouth
- □Jaw Problems (TMJ)
  - □Clicking?
  - □Pain?
  - □Difficulty Swallowing?
  - □Difficulty Chewing?
- □Orthodontics/Invisilign
- □Periodontal Disease
- □Teeth Clenching
- □Teeth Grinding
- □Tooth Pain
- □Wisdom Teeth Extraction
- □Do You Wear Removable Teeth?

Musculoskeletal

- □Back Pain
- □Fibromyalgia
- □Joint Pain

Neurological

- □Alzheimer's Disease
- □Dizziness
- □Fainting
- □Memory Loss
- □Multiple Sclerosis (MS)
- □Muscle Weakness
- □Seizures
- □Stroke
- □Tingling/Numbness
- □Trigeminal Neuralgia
- □Tremor

Psychiatric

- □ADD/ADHD
- □Anxiety
- □Chemical Dependency
- □Eating Disorders
- □Excessive Stress
- □Memory Problems

Respiratory

- □Asthma
- □Bronchitis
- □Breathing Problems
- □Chest Pressure
- □Congestion
- □Dyspnea(Shortness of Breath)
- □Emphysema
- □Orthopnea
- □Pneumonia
- □Pulmonary Embolism
- □Tuberculosis

Sleep

- □Daytime Sleepiness
- □Morning Headaches
- □Obstructive Sleep Apnea
- □Do you use a CPAP? How Often?_____
- □Has anyone told you that you snore?

Social History

- □Do you Smoke? _____Packs a Day?
- □Do you use Smokeless Tobacco?
- □Do you Consume Alcoholic Beverages? _____ Drinks per Day/Week/Month
- □Do you use Recreational Drugs?

CONFIDENTIAL

MEDICAL HISTORY and CONSENT

List any medications you are taking:

Medication	Dosage/Freq.	Reason
1.		
2.		
3.		
4.		
5.		
6.		

List any Surgeries or hospitalizations you have had:

Date(Yr.)	Surgery	Reason
1.		
2.		
3.		
4.		
5.		
6.		

List and detail any medical condition or history not listed above:

_____

_____

_____

Primary Physician's Name:_____ **Physician's Phone#(____)____-_____**

Are you under the care of other physicians? If so, please list:

Physician Name **Phone#** **Reason**

_____

_____

_____

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Westwood Dental to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the medication, and therapy that may be necessary and further consent that Westwood Dental choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Westwood Dental. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a finance charge that will be applied to any balance over 90days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Westwood Dental staff to verify insurance coverage, if any, to submit claims, and to provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (adult):

Name of Patient(*Print*)_____ Date_____

Signature of Patient_____ Date_____

Consent (for a minor child):

Name of Parent/Guardian_____ Date_____

Signature of Parent/Guardian_____ Date_____

Notice of Privacy Practices(below)

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information (PHI)and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company(if any applicable)and my other medical providers.

Signature of Patient _____ **Date**_____

WESTWOOD DENTAL POLICIES

Patient Name(please print)_____DOB_____

Missed Appointments

I understand that Westwood Dental may, but not required to, do one or all of the following, concerning my appointment information:

1. Call my home/cell/work phone number
2. Text my cell phone number
3. Email the email address on my account

I understand that this is a courtesy and that I am ultimately responsible to keep appointment date and time. I understand that Westwood Dental may charge a *$50.00 MISSED APPOINTMENT* fee for appointments that are missed or canceled within 24 hours prior to my scheduled appointment.

Patient Signature_____Date_____

After Hours Phone Calls "EMERGENCY PHONE SERVICE"

The Emergency phone line is to be used only for serious and true Dental Emergency concerns that require attention that cannot wait until the next business day. If you do NOT have a true emergency you may leave a message on our answering machine and you will be contacted the next business day.

You must be a current patient of record to have an Emergency return phone call (current patient defines being seen by a Westwood Dental Doctor within 1 year).

Westwood Dental's normal phone business hours are Monday through Thursday 7:00am to 5:00pm and Friday's 9:00am to 1:00pm. We encourage our patients to call during normal business hours.

Patient Signature_____Date_____

Medical Records Release

Westwood Dental will only release our patient's medical records when a valid HIPAA compliant authorization or a court-Ordered subpoena is received.

Patient Signature_____Date_____