Westlake Family Dental

Patient Registration

Thank you for choosing our office to assist you with your dental needs.
Please fill out the information below and don't forget to provide your signature at the end.

Patient's name _____ Date of Birth _____

Sex:_____

If minor, name of legal guardian_____

Home phone _____ Mobile phone _____ Work phone_____

Email address:_____

Mailing address _____ City _____State _____ Zip _____

Employer _____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your SS# : _____ or Member ID#_____

Dental Insurance Co._____ Group number_____ Claims Address_____

Covered by spouse's insurance? ❑ yes ❑ no Spouse's Name _____

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ SS# or Member ID# _____

MEDICAL HEALTH HISTORY

Do you have, or have you had any of the following? (Please check any that apply)

❑ **Are you required to Pre-medicate before any dental treatment?**

- ❑ Blood Problems (Anemia)
- ❑ Blood transfusion
- ❑ Heart problems
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Heart Pacemaker
- ❑ Stroke
- ❑ Bone or joint problems
- ❑ Artificial joint or valves
- ❑ High or low blood pressure High Low
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis, jaundice or other liver disease
- ❑ Diabetes TYPE 1 or TYPE 2
- ❑ Epilepsy or Neurological disorders
- ❑ Thyroid problems
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Cancer/Tumor
- ❑ Abnormal bleeding after any surgery (heavy bleeder)
- ❑ Hayfever or sinus trouble
- ❑ Allergies
- ❑ Asthma

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners e.g. Coumadin)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin other diabetes drugs
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Natural supplements
- ❑ Other:_____

Women:

- ❑ Are your pregnant or plant to become pregnant
- ❑ Taking hormones or contraceptives

Do you smoke,vape or use tobacco? ❑ yes ❑no

Name of your primary medical physician:_____ Phone number_____

Signature of patient (or parent) _____ Date _____

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records, examination results, medication dose changes, and claims information.
This information may be released to:

☐ - Spouse _____

☐ - Child(ren) _____

☐ - Other _____

☐ - Information is not to be released to anyone other than me.

Messages

Please call ☐ my home phone is _____ ☐ my cell phone is _____

If unable to reach me:

☐ - You may leave a detailed message

OR

☐ - Please leave a message asking me to return your call

☐ - Do not leave messages on my phone mailbox.

The best time to reach me is (day of week)_____ between (time)_____

E-mail Messages

☐ - Use my e-mail address to send messages for me to contact the nurse for information **OR**
☐ - Use my e-mail to leave detailed messages and information.

☐ Attach lab results to the e-mail message.

My e-mail address is _____

This Release of Information will remain in effect until terminated by me in writing.
This release ***specifically excludes*** any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Patient Signature: _____ Date: ____/____/____

Witness Signature:_____ Date: ____/____/____

PLEASE READ

FINANCIAL POLICY for Westlake Family Dental

Insurance

_____*As a courtesy, Dr. Burns will submit a claim to your insurance company for services rendered.* ***However, all co-pays and patient portions are due at the time of service.***

_____***Although Dr. Burns is not on any list (DMO, PPO, HBO, RSVP, LMNOP) we can still file a claim on your behalf, as long as YOU have the freedom to choose to go to any dental provider. (WE ARE AN OUT-OF-NETWORK PROVIDER)***

_____*We do not file a secondary insurance policy that is the patient's responsibility.*

_____*Our office does not verify benefits; therefore the patient must know their policy. Some policies pay once per year, some pay more. We have no way of knowing since we are a third party.*

_____*I further understand that if my insurance company does not pay for these services for any reason, I will accept financial responsibility for any* ***partial or non-payment*** *of services.*

_____*If after 60 days the insurance company has not paid, I understand that it is* ***MY RESPONSIBILITY TO PAY THE ENTIRE BALANCE IN FULL.***

All Accounts

_____*All charges incurred are due on the date of service, unless prior arrangements have been made at the front desk.*

_____*Should your balance become past due, we do refer all past due accounts to a collection agency.* ***Our collection agency does report to all of the National Credit Bureau's and charges a 40% collection fee in addition to the reported balance.***

Financing

Westlake Family Dental offers 0% financing through Care Credit, and we do offer prepayment discounts on treatment over $500.00.

_____

Patient/Guardian Signature *Date*

Westlake Family Dental

Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least **24** hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a charge for not showing up for scheduled appointments. ***Repeated cancellations or missed appointments will result in loss of future appointment privileges.***

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

X_____

Patient signature Date

_____

Patient name printed Date

_____

Witness Date

Westlake Family Dental

Agreement to Receive Electronic Communication

Patient Name: _____Date of Birth: _____

(Initial below)

I ____ DO AGREE

I_____ DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial below)

___Text Messaging

___ Email

I would like to receive:

___ Appointment Reminders/Recall Visits

___ Information regarding insurance/billing

___ Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at any time by calling: Westlake Family Dental |512 328-0911|OFFICE EMAIL ADDRESS:admin@wlfamilydental.com

Patient Signature: _____**Date:**_____

WESTLAKE FAMILY DENTAL
GENERAL CONSENT FOR TREATMENT

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics **(gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.**

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient or Guardian Name Date

_____ _____

Witness Date

Westlake Family Dental

Dental Questionnaire

Comprehensive Exam

Dental Treatment Questions:

1. Do you feel nervous about having dental treatment?..... ☐ **Yes** ☐ **No**
2. Do you want to discuss sedation options? ..... ☐ **Yes** ☐ **No**
3. Have you been treated with Orthodontics in the past?..... ☐ **Yes** ☐ **No**
4. Do you want straighter teeth?..... ☐ **Yes** ☐ **No**
5. Are you satisfied with the appearance of your teeth?..... ☐ **Yes** ☐ **No**
6. If you could have your teeth whitened, would you be interested?..... ☐ **Yes** ☐ **No**
7. Have you ever had an oral cancer exam?..... ☐ **Yes** ☐ **No**
8. Do you have areas that are difficult to floss?..... ☐ **Yes** ☐ **No**
9. Do you have areas where food catches between your teeth?..... ☐ **Yes** ☐ **No**
10. Have you noticed any spots or stains on your teeth that concern you?..... ☐ **Yes** ☐ **No**
11. Are there old fillings or dental work you would like to change?..... ☐ **Yes** ☐ **No**
12. Do you snore?..... ☐ **Yes** ☐ **No**
13. Do you wake up in the morning still feeling tired?..... ☐ **Yes** ☐ **No**
14. Do you have tired jaws, especially in the morning?..... ☐ **Yes** ☐ **No**
15. Do you wear removable dentures or partial dentures?..... ☐ **Yes** ☐ **No**
16. Are you using any other dental devices (i.e. retainer, bite guard, snoring appliance)?.. ☐ **Yes** ☐ **No**
17. Do you have an unpleasant taste or bad breath?..... ☐ **Yes** ☐ **No**
18. Do you think your dental health affects your overall physical health?..... ☐ **Yes** ☐ **No**

Westlake Family Dental

Dental Hygiene Questions:

19. Date of last dental cleaning?.....

20. How often do you brush?.....

21. What do you use to clean your teeth/gums?.....

- ☐ **Manual Toothbrush**
- ☐ **Electric Toothbrush**
- ☐ **Floss**
- ☐ **Toothpick**
- ☐ **Waterpick**
- ☐ **Fluoride Rinse**
- ☐ **Tongue Blade**

22. Have you ever been told that you have periodontal disease?..... ☐ **Yes** ☐ **No**

23. Do your gums bleed when brushing/flossing?..... ☐ **Yes** ☐ **No**

24. Are you currently using any prescription toothpaste or mouthwash?..... ☐ **Yes** ☐ **No**