# PATIENT INFORMATION

*Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.*

Patient's name _____ Preferred name _____ Birth date_____SS#_____
If minor, parents names _____ Home phone _____ Cell phone _____
Mailing address _____ City _____State _____ Zip _____
Employer _____ Occupation _____
Spouse's name _____ Spouse's phone _____ ❑ Unmarried
Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION: ❑ **Not covered by dental insurance**
Subscriber name: _____ Subscriber birthday:_____ Subscriber insurance:_____
Subscriber ID#:_____Group#:_____Insurance phone#:_____

## MEDICAL HEALTH HISTORY

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

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

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

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

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____
  _____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____
Do you have any disease, condition, or problem not listed above?_____
_____
Please add anything else you would like us to know about:_____
_____

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: ____/____/____

**COVID-19 (Novel Coronavirus) Pre-Screening Questionnaire**

The only way to confirm if you have COVID-19 is to get tested with a kit, and those are in short supply. However, we can work together to help minimize the risks of further spreading COVID-19 (novel coronavirus). Please fill out this questionnaire to help us understand how we can prepare to serve you.

Pre-Screening Questions:

1. Have you recently traveled to an area of high-risk for COVID-19?

   ❑ Yes ❑ No

2. Have you been around someone who recently traveled to a high-risk area and is also sick?

   ❑ Yes ❑ No

3. Have you been around someone who is known to have the Coronavirus (COVID-19)?

   ❑ Yes ❑ No

4. Have you been told by a health official that you may have been exposed to the virus?

   ❑ Yes ❑ No

5. Have you had a fever recently? Or do you think you have a fever?

   ❑ Yes ❑ No

6. Do you have a cough?

   ❑ Yes ❑ No

7. Do you have any of these?
   - Fatigue
   - Body aches

   ❑ Yes ❑ No

8. Are you feeling mild to moderate shortness of breath or mild to moderate difficulty breathing?

   ❑ Yes ❑ No

9. Are you experiencing symptoms that feel like a life-threatening medical emergency?
   For example:
   - Severe shortness of breath and difficulty breathing
   - Crushing chest pain
   - Loss of consciousness
   - Slurred speech

   ❏ Yes ❏ No

10. COVID-19 can affect the elderly or the very young more seriously than others. How old are you?
    Age: _____

11. Do you have any of the following? Please select all that apply.
    ❏ High blood pressure
    ❏ Diabetes
    ❏ Heart disease
    ❏ Lung disease
    ❏ Kidney disease
    ❏ Liver disease
    ❏ None of the above

12. COVID-19 can affect people who have weaker immune systems from things like chemotherapy, HIV/AIDS, organ transplant, being pregnant, or prolonged steroid use. Do you have a weakened immune system from a known cause?

    ❏ Yes ❏ No

# Financial Policy

At Westlake Family Dental our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment unless prior arrangements made.

Payment options:
1. Cash
2. Check
3. MasterCard
4. Visa
5. Discover
6. American Express
7. CareCredit
8. Credit card authorization for recurring charges:
    a. Treatment exceeds $200
    b. Plan may not exceed 4 months

Patient with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance. We are an OUT-OF NETWORK PROVIDER.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

18% annual interest is charged for any unpaid balance. A $15 fee is charged for nonpayment.

There is a $30.00 processing charge for non-sufficient funds or returned checks.

Records can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a $25 - $50 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 24 HOURS IN ADVANCE.

I, _____, agree to these financial terms.

Signature _____ Date_____

# Westlake Family Dental General Consent form
## 4201 Bee Caves Rd. B210
## Austin, TX 78746

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.

7. I agree to electronic communication via email and text, regarding appointments, treatment, insurance and billing. **Email address: _____**

_____ _____

**Patient or Guardian Name** **Date**

_____ _____

**Witness** **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

# 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**

***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**

# PLEASE PARK&TEXT

**To prevent the spread of COVID-19, we're asking patients to wait in their cars rather than in the waiting room.**


**Please text or call the number below once you've arrived.**

**(512)328-0911**

Thank you!