MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME: MR./MISS/MRS./MS./DR.

DATE OF BIRTH (DAY/MONTH/YEAR): / /

ADDRESS (HOME):

PHONE:

ADDRESS (BUSINESS):

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

❑ YES ❑ NO ❑ NOT SURE/MAYBE

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.

❑ YES ❑ NO ❑ NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

❑ YES ❑ NO ❑ NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below:

❑ YES ❑ NO ❑ NOT SURE/MAYBE

a) medications
b) latex/rubber products
c) other (e.g. hayfever, foods)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

❑ YES ❑ NO ❑ NOT SURE/MAYBE

7. Do you have or have you ever had asthma? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice or liver disease? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ❑ YES ❑ NO ❑ NOT SURE/MAYBE

15. Do you have or have you ever had any of the following? Please check.

- ❑ chest pain, angina
- ❑ heart attack
- ❑ stroke
- ❑ shortness of breath
- ❑ rheumatic fever
- ❑ mitral valve prolapse
- ❑ heart murmur
- ❑ pacemaker
- ❑ lung disease
- ❑ tuberculosis
- ❑ cancer
- ❑ steroid therapy
- ❑ diabetes
- ❑ stomach ulcers
- ❑ arthritis
- ❑ seizures (epilepsy)
- ❑ kidney disease
- ❑ thyroid disease
- ❑ drug/alcohol dependency
- ❑ osteoporosis medications (e.g. Fosamax, Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If so, what? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ❑ YES ❑ NO ❑ NOT SURE/MAYBE

18. Do you smoke or chew tobacco products? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

19. Are you nervous during dental treatment? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

20. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: **DATE:**

DENTIST SIGNATURE: **DATE:**

DENTIST'S NOTES

INSURANCE AND ACCOUNT INFORMATION

Person financially responsible for this account:

Name:_____ Relationship to patient:_____

Billing Address:_____

City: _____ State: _____ Zip: _____

SS #: _____ Driver's License #: _____

Work Phone # (_____) _____

Payment Method:

- ❑ Cash ❑ Check ❑ CareCredit
- ❑ Credit Card: (number) _____ EXP: ___ /____

If you have Dental Insurance, please complete the following section

Primary Dental Insurance:

Company Name: Name of Insured:

_____ _____

Address_____ State _____ Zip: _____

City _____ Phone Number: (_____)_____

Insured's ID#: _____ Relationship: _____

Group # (Plan, Local, or Policy Number): _____

Insured Date of Birth: ____/____/_____ Employer: _____

Secondary Dental Insurance:

Company Name: Name of Insured:

_____ _____

Address_____ State _____ Zip: _____

City _____ Phone Number: (_____)_____

Insured's ID#: _____ Relationship: _____

Group # (Plan, Local, or Policy Number): _____

Insured Date of Birth: ____/____/_____ Employer: _____

_____ *(Initial)* I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

_____ (*Initial*) I authorize the release of the above information only as it is required to process insurance claims

FINANCIAL POLICY FOR OUR PATIENTS

We will strive to make dental care affordable for all of our patients. We proudly offer the following financial policy so that our patients can have the opportunity to decide which payment options best suit their needs.

Payment Options

1. Credit Cards – Our office accepts American Express, Discover, MasterCard, Visa, and Debit cards
2. Third party Financing – Upon qualifying you will be extended a line of credit for treatment costs by an outside financing company (ex – CareCredit). All subsequent payment will be made directly to the financing company. The qualification process is simple and can usually be completed within 20-30 minutes. Multiple financing terms and options are available, and for further information please ask our financial coordinator. No additional office discounts will apply when using outside financing.
3. Senior Citizen's Courtesy – Ask us about our Senior's Courtesy Discount.

Insurance: Our office understands the value of insurance benefits to our patients and will gladly work with you to help get the maximum benefit available to you. However, your insurance contract is between **you, your employer, and your insurance company.** Most dental benefits do not pay 100% of the cost of your treatment. As a result, and combined with the extreme delay in receiving payments from insurance companies, you will be asked to pay your deductible and your portion of charges the day of services rendered. We will **estimate** your coverage as best we can, however we are unable to precisely calculate what your insurance payment will be in every case. As a courtesy, we will assist you with contacting your insurance company, but the ultimate responsibility of payment lies with you. After 30 days outstanding, any balance will be due in full.

We would be happy to work with you to plan out the most appropriate arrangements for your budget. Financing your treatment allows you to start your dental care immediately and spread the payment over a longer time period. Most importantly, it offers the opportunity to enjoy the benefit of dental health without the financial strain.

Related Information:

1. Payment is due when services are rendered. Fees of $300.00 or less must be paid in full at the time of your appointment, unless other arrangements have been made.
2. Returned checks and billing services are subject to additional fees. Accounts over 60 days will be charged a monthly billing fee. These additional fees will be applied to the unpaid balance at the end of the month.
3. In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for the collection of the outstanding bill
4. Your dental appointments are reserved exclusively for you. We require a minimum of 48 hours notice to reschedule any dental appointment. Failure to give adequate notice will result in a $50 missed appointment charge.

I have read and understand the above information. I understand that I am responsible for any charges incurred from dental services rendered.

SIGNATURE:_____

NAME (Print): _____ Date: ___/____/_____

DENTAL HISTORY QUESTIONNAIRE

We would appreciate you answering these confidential questions regarding both your past and current dental health:

Name: _____ Date: _____

What is the reason for your appointment: _____

Name of Previous Dentist: _____

Approximate date of last dental Exam: ___/___/____ Last X-rays: ___/___/____

In the past have you:

Had your wisdom teeth removed?	Yes	No
Had braces or orthodontic treatment?	Yes	No
Had oral surgery other than wisdom Teeth?	Yes	No
Taken Pre-Medication?	Yes	No

Do you currently:

Want whiter teeth?	Yes	No
Have Sensitive Teeth?	Yes	No
Have chipped or broken teeth?	Yes	No
Grind or clench your teeth?	Yes	No
Use a nightguard or wear retainers?	Yes	No
Need braces?	Yes	No
Have crooked, uneven, or rotated teeth?	Yes	No
Think your teeth are too large or small?	Yes	No
Want to change the size - or shape of your teeth?	Yes	No
Want to replace your metal fillings?	Yes	No
Use Dental Floss?	Yes	No

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided. I authorize the staff of Westlake Dental Associates to perform any necessary services during diagnosis and treatment.

Sign: _____ Date: ____/____/_____

ACKNOWLEDGEMENT OF RECEIPT:
NOTICE OF PRIVACY PRACTICES

DR SCOTT R LUNDY DDS DR THOMAS F WUESTHOFF DDS MAGD
176 AUBURN CT SUITE 5 WESTLAKE VILLAGE, CA 91362
805-496-4247

You may refuse to sign this acknowledgement

I, (Print Name) _____ have received a

copy of this office's *Notice of Privacy Practices.*

Print Name: _____

Patient Signature _____ Date_____

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our "notice of Privacy Practices" but acknowledgement could not be obtained because:

- o Individual Refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify below)

_____

_____

_____