WESTLAKE
DENTAL ASSOCIATES

Medical History Questionnaire

Personal Information

First Name: ____________________ Last Name: ____________________

Home Address: ____________________ Date of Birth ________ / ________ / ________

____________________ Home Phone: (   ) ____________________

Email: ____________________ Cell Phone: (   ) ____________________

Work Address: ____________________ Work Phone: (   ) ____________________

____

Occupation ____________________ How did you hear about our office? ____________________

Current Medical Doctor Information

Family Doctor: ____

Office Address ____________________ Doctors Phone: (   ) ____________________

____

____

Are you under the care of a medical specialist? Please provide their information below

Doctor’s Name ____

Office Address ____________________ Area of Specialty: ____________________

____________________ Doctor’s Phone: (   ) ____________________

Doctor’s Name ____

Office Address ____________________ Area of Specialty: ____________________

____________________ Doctor’s Phone: (   ) ____________________

In Case of Emergency Please Notify

Name: ____

Phone Number: ____

Relationship: ____

Medical History

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 out the entire form.

Are you being treated for any medical condition at the present or have you been treated within the past year?
If so, please explain below:

____

____

When was your last medical checkup?______________________________

Has there been any change in your general health in the past year? If so, please explain below:

____

____

Are you taking **ANY** prescription medications, non-prescription medications, or herbal supplements of any kind?
Please list all of them below:

____

____

Are you allergic to **ANY** medications? ☐ Yes ☐ No ☐ Not sure/Maybe
If so which: ____________________

Are you allergic to **latex** or **rubber** products? ☐ Yes ☐ No ☐ Not sure/Maybe

Any other allergies? (Hayfever? Foods?) Please list below:

____

Have you ever had a peculiar or adverse reaction to any medicines or injections? If so please explain below:

____

____

Question			
Do you have or have you ever had asthma?	☐ Yes	☐ No	☐ Not sure/Maybe
Do you have or have you ever had any heart or blood pressure problems?	☐ Yes	☐ No	☐ Not sure/Maybe
Do you have a prosthetic or artificial joint?	☐ Yes	☐ No	☐ Not sure/Maybe
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 (congenital heart disease) or a heart transplant?	☐ Yes	☐ No	☐ Not sure/Maybe
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
Have you ever had hepatitis, jaundice or liver disease?	☐ Yes	☐ No	☐ Not sure/Maybe
Do you have a bleeding problem or bleeding disorder?	☐ Yes	☐ No	☐ Not sure/Maybe

Have you ever been hospitalized for any illness or operations? If yes, Please explain below: ☐ Yes ☐ No ☐ Not sure/Maybe

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Do you have or have you ever had any of the following? Please check all applicable boxes:

- ☐ Chest Pain, Agina
- ☐ Heart Attack
- ☐ Stroke
- ☐ Shortness Of Breath
- ☐ Kidney Disease
- ☐ Osteoporosis Medications: (Fosamax , Actonel)
- ☐ Rheumatic Fever
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Thyroid Disease
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Steroid Therapy
- ☐ Seizures
- ☐ Diabetes
- ☐ Stomach Ulcers
- ☐ Arthritis
- ☐ Drug/Alcohol Dependency

Are there any conitions or diseases not listed above that you have or have had? If so, what?

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer, or heart disease) If so, please explain below: ☐ Yes ☐ No ☐ Not sure/Maybe

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Do you **smoke** or **chew tobacco** products? ☐ Yes ☐ No ☐ Not sure/Maybe

Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not sure/Maybe

For women only: Are you breastfeeding? ☐ Yes ☐ No ☐ Not sure/Maybe

For **women only:** Are you pregnant? ☐ Yes ☐ No ☐ Not sure/Maybe

If so, expected delivery date: _________/_________/________

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

Patient Signature: ______________________ Date: ______________________

Dentist Signature: ______________________ Date: ______________________

Dentist's Notes:

WESTLAKE
DENTAL ASSOCIATES

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

Our complete privacy practice document is always available at the front desk.
We are happy to provide additional email or paper copies at any time if desired.

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:

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

____
____
____

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 monthly.
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: ___/____/_____

WESTLAKE
DENTAL ASSOCIATES

For Office Use Only	
File Number	

Insurance and Account Information

Person Financially Responsible For This Account

First Name: ______________________ Last Name: ______________________

Date of Birth: ____/____/____ Relationship to Patient ______________________

Billing Address: ______________________ Home Phone ( ) ______________________

______________________ Cell Phone ( ) ______________________

______________________ Work Phone ( ) ______________________

Social Security # ______________________ Driver's License ______________________

Payment Method: ☐ Cash ☐ Check ☐ CareCredit

Dental Insurance Information

Primary Dental Insurance

Company Name ______________________

Address: ______________________

____

____

Insured's ID# ______________________

Group #
(Plan, Local, or Policy #) ______________________

Name of Insured: ______________________

State: ______________________ Zip Code ______________________

Phone Number ( ) ______________________ Relationship: ______________________

Social Security of Insured ______________________ Insured Date of Birth: ____/____/____

Employer: ______________________

Secondary Dental Insurance

Company Name ____________________

Address: ____________________

____

____

Insured's ID# ____________________

Group #
(Plan, Local, or Policy #) ____________________

Name of Insured: ____________________

State: ____________________ Zip Code ____________________

Phone Number (   ) ____________________ Relationship: ____________________

Social Security of Insured ____________________ Insured Date of Birth: ____/____/____

Employer: ____________________

Authorization

__________ *(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 hereby authorize the release of the above information only as it is required to process insurance claims.

Signature: ____________________ **Date**: ____________________