JEFFREY C. WEST, DMD - General Dentistry

Health History Questionnaire

Name _____ **Date of birth** _____ **Today's Date** _____

MEDICAL HISTORY

1. Name and phone number of physician(s): _____
2. Are you currently taking any medications, pills, or drugs? Yes No
   - If yes, please list: _____
3. Do you have any allergies (latex, penicillin, sulfa drugs, dental anesthetic, etc.)? Yes No
   - If yes, please list: _____
4. Do you currently smoke or drink alcohol? Yes No
   - If yes, how much? Smoke: _____ packs per day Drink: _____ drinks per week
5. Have you ever taken bisphosphonates (Actonel, Boniva, Fosamax, Reclast, Zometa, etc.)? Yes No
   - If yes, please explain: _____
6. Do you currently have or have you ever had any of the following?

• Heart Disease	Yes	No	• Artificial Joints	Yes	No
• Heart Murmur	Yes	No	• Cancer or Tumors	Yes	No
• Mitral Valve Prolapse	Yes	No	• Radiation or Chemotherapy	Yes	No
• Rheumatic Fever	Yes	No	• Aids or HIV	Yes	No
• Stroke	Yes	No	• Sexually Transmitted Disease	Yes	No
• High Blood Pressure	Yes	No	• Hepatitis or Liver Disease	Yes	No
• Asthma	Yes	No	• Kidney Disease	Yes	No
• Blood Disease	Yes	No	• Stomach or Intestinal Issues	Yes	No
• Excessive Bleeding	Yes	No	• Tuberculosis	Yes	No
• Diabetes	Yes	No	• Major Operation or Illness	Yes	No
• Epilepsy or Seizures	Yes	No	• Females: Are you pregnant?	Yes	No
• Fainting spells	Yes	No	• Females: Are you nursing?	Yes	No
• Arthritis	Yes	No			

If yes to any of the above, please explain: _____

_____

DENTAL HISTORY

1. What dental problem/concern brought you in today? _____
2. Do you have any dental concerns, worries, or complaints? _____
3. How often do you brush and floss your teeth? Brush: _____ per day Floss: _____ per week
4. When was your last dental visit? _____ Have you recently had any dental x-rays? Yes No
5. Have you ever had any complications following dental treatment? Yes No
   - If yes, please explain: _____
6. Have you ever suffered an injury to your teeth, jaws, or face? Yes No
   - If yes, please explain: _____
7. Are you happy with the appearance of your teeth and smile? Yes No
   - If no, please explain: _____
8. Do you grind your teeth? Yes No
9. Do you experience jaw pain? Yes No

I understand the need for these questions to be answered truthfully and to the best of my knowledge. I also understand it is very important to report any change in my medical or dental status to the dentist at the earliest possible time and I agree to do so.

Signature of person completing this form_____ Date _____

If other than patient, relationship _____

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Thank you for selecting our dental team! To help us meet all your dental needs, please fill out this form completely in ink. Your information is for our records only and is considered confidential. Don't hesitate to ask us if you have any questions or need assistance.

Patient Information

Full Name _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

Telephone (mobile) _____ (home) _____ (other) _____

Email Address _____

Date of Birth _____ Sex _____ Race _____ Marital Status _____

Social Security # _____

Occupation _____ Employer _____

Emergency Contact Name and Relationship _____ Telephone _____

How did you hear about our office? _____

Dental Insurance Information

Insurance Company _____ Group/Plan # _____

Member Identification # _____

Insurance Company Telephone _____ Effective Date of Insurance _____

Insurance Company Address for Claims _____

_____

Are you the policy holder? ☐ Yes ☐ No

If not, please provide the following information:

- Policy Holder Full Name _____
- Policy Holder Date of Birth _____
- Policy Holder Social Security # or Member Identification # _____
- Policy Holder Occupation and Employer _____

Responsible Party (If you are under the age of 18 please have the responsible party fill out the information below)

Full Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Telephone (mobile) _____ (home) _____ (other) _____

Email Address _____ Date of Birth _____

Social Security # _____

Occupation _____ Employer _____

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Jeffrey C. West, DMD Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any dental services being rendered.

Regarding Dental Insurance

This office is not in-network (eg: a participating provider) with any insurance company. This means we are not a party to your insurance contract, nor do we know your benefit levels. Please verify your insurance status and coverages before your appointment. No insurance company attempts to cover all dental costs. This office, as a courtesy, processes your insurance claims at no cost to you, allowing only your deductible and a 50% payment of balance to be paid for procedures (ie: fillings, crowns, root canals, extractions) as opposed to paying the entire cost at the time of visit. **If your insurance does not pay within sixty days, payment is due in full by you.** Any payment subsequently made by your insurance company in excess of the balance on your account will be refunded to you. Any balance due to plan limitations is your responsibility payable within fifteen days. **Patients with Delta Dental and Blue Cross Blue Shield of NC insurance will be required to pay in full at the time of your appointment and you will be reimbursed in the mail after we file the paperwork for you. Patients with Blue Cross Blue Shield Federal will be required to pay in full at the time of your appointment and paid invoices will be provided so that you can file for reimbursement.**

Payment Options

We accept cash, check, Visa and Mastercard at check out the day treatment is rendered. We also offer payment options for larger treatment plans and for treatment requiring several appointments. We will discuss all payment options during the treatment-planning phase and will offer a description of all services with detailed fees and sequencing.

Missed Appointments

Please help us serve you better by keeping scheduled appointments. We never overbook appointments, so each appointment is a time reserved specifically for you. Unless cancelled at least 48 business hours in advance, habitually missed appointments will be charged a $50 fee.

Thank you for understanding the necessity of our financial policy. Please let us know if you have any questions or concerns regarding any of the above.

I have read, understand and agree to this financial policy.

_____ _____

Signature of Patient (If patient is under 18 a parent or guardian must sign) Today's Date