West Gate Family Dentistry

www.thewestgatedental.com
office@thewestgatedental.t
3381 West Main | Suite 3 • St. Charles, IL 60175
(630)513-2121

Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** _____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Frit ☐ Morning ☐ Afternoon ☐ Evening ☐ Any time

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School ☐ Work

☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Primary Medical Insurance:

Name of Insured: _____ _____ _____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent, or guardian (responsible party):

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

_____

Response Date: _____

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Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

What is the date (or approximate date) of your last medical exam?

_____

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?
☐ Are you currently under the care of a physician due to a specific condition?
☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
☐ Are you currently taking any prescription or non-prescription medications?
☐ Do you use tobacco (smoking, chewing or Vaping)?
☐ Do you require the use of corrective lenses (contacts or glasses)?
☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

_____

_____

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Please check all that apply:

- ☐ A Fib
- ☐ Alzheimer
- ☐ Anxiety
- ☐ Asthma
- ☐ COPD
- ☐ Clindamycin Allergy
- ☐ Depression
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Palpitations
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lidocaine Allergy
- ☐ Lupus
- ☐ Multilple Sclerosis
- ☐ Osteoporosis
- ☐ Penicillin Allergy
- ☐ Rheumatic Fever
- ☐ Seasonal Allergies
- ☐ Stomach Problems
- ☐ Tree Nut Allergy
- ☐ Tumors
- ☐ lichen sclerosus
- ☐ ADD/ADHD
- ☐ Amoxicillin Allergy
- ☐ Arthritis
- ☐ Autism
- ☐ Cancer
- ☐ Crohns Disease
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Kidney Stones
- ☐ Lidocaine Allergy
- ☐ Memory Loss
- ☐ NSAIDS
- ☐ PANS
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tremors
- ☐ Ulcerative Colitis
- ☐ spinal injury
- ☐ Acid Reflux
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Celiac Disease
- ☐ Dairy Allergy
- ☐ Epilepsy/ Seizures
- ☐ Food Allergies
- ☐ HIV
- ☐ Heart Disease
- ☐ Hepatitis B
- ☐ Ibuprofen allergy
- ☐ LATEX ALLERGY
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Sarcodosis
- ☐ Sleep Apnea
- ☐ TMJ/TMD Issues
- ☐ Trigeminal Neuralgia
- ☐ Vertigo
- ☐ Allergies
- ☐ Angina
- ☐ Aspirin Allergy
- ☐ Brain aneurysm
- ☐ Cleocin Allergy
- ☐ Defibrillator
- ☐ Excessive Bleeding
- ☐ GERD
- ☐ Hashimotos
- ☐ Heart Murmur
- ☐ Herniated Disc
- ☐ Jaundice
- ☐ Leukemia
- ☐ Low Blood Pressure
- ☐ Migraines/Headaches
- ☐ Nut Allergy
- ☐ Parkinson's Disease
- ☐ Respiratory Problems
- ☐ Sclerderma
- ☐ Stent
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vicodin Allergy

Please list all current medications, including vitamins and supplements that you are currently taking:

_____

_____

_____

_____

_____

Please specify any allergies or health issues:

_____

_____

_____

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please check all that apply:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient:

Response Date: _____

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ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Westgate Dental Notice of Privacy Practices. By signing below, I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Print Name Patient Date of Birth

Signature _____ **Date** _____

Response Date: _____