Welcome to Westnedge Family Dentistry

_____ _____

Name Name you go by

How did you find out about us? Friend or Family? Name: _____We would like to thank them.

Yellow Pages _____ ATT yellow pages_____ Yellow Book_____ Internet_____

Sign_____ Other (What was it?) _____

Dental History

Who was your previous dentist? _____

How long since your last teeth cleaning? _____

Did you have x-rays taken? Yes or No If yes, when were the last ones taken? _____

Have you been told you have periodontal disease (gum infection)? _____

What is your primary dental concern? _____

Insurance and Financial Policy

Your dental benefits are based on a contract between you and your insurance company. We are happy to process your claims and help you determine what your benefit plan may cover. Your **estimated** copays and deductibles are due on the day of service. We accept Master Card, Visa, American Express, Discover, Care Credit, personal checks or cash. Should your insurance not pay within 60 days we reserve the right to require payment in full from you and let you collect insurance reimbursement. **Ultimately, you are responsible for all charges incurred in our office.**

Any unpaid balances at 30 days may incur a late charge of 1½ % per month and/or a five dollar billing charge.

Appointments

We have reserve a specific amount of time for you and we encourage you to keep your appointment. We attempt to confirm all appointments ahead of time. If a change must be made, please give us the courtesy of at least 24 hour notice to avoid a cancellation fee.

Assignment and Release

I agree with the above conditions. I understand that I am financially responsible for all charges. I authorize the doctor to release all information necessary to secure payment. I authorize the use of this signature on all insurance submissions. I consent to the diagnosis and/or treatment necessary for proper dental care.

Signature: _____ Date:_____

WESTNEDGE FAMILY DENTISTRY
3907 S. WESTNEDGE AVE.
KALAMAZOO, MI 49008
Phone: (269) 345-8893

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For 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)

_____

_____

_____

Last Name First Name

Email

Address

Home Phone #

City, State, Zip

Work Phone #

Employer

Cell Phone #

In case of emergency / Phone #

Date of Birth

Physician's Name / Phone #

Social Security #

Insurance Carrier or any changes of coverage

Secondary coverage

Health History

1) Are you allergic to any medications or latex? (If yes, please list) YES NO NOT SURE

2) List any medications or drugs including over the counter, aspirin, herbal supplements and birth control you are taking:

3) What purpose are these medications for:

4) Do you have any problems affecting any of the following: YES NO NOT SURE

A. Heart
B. Lungs
C. Kidney
D. Liver
E. Other medical conditions we should be aware of

5) Have you ever had rheumatic fever, an artificial hip, knee replacement, Heart murmur or been told you need to be premedicated prior to dental work?

6) Have you ever had hepatitis? (If yes, what type A,B, or C)

7) Have you ever tested **positive** for HIV?

8) Are you feeling well today?

9) Are you currently under the care of a physician?

10) Do you smoke or use other tobacco products (chew)?

11) Are you pregnant?

12) Are you taking or taken Oral Bisphosphonates eg. Fosamax, Actonel, Bonivia Or IV Bisphosphonates eg. Zometa, Aredia for osteoporosis or other reasons?

Additional Comments:

Today's date Dr.'s Signature Patient / Guardians Signature