Kenneth L. Westbrook, DDS

Patient Information (Confidential)

Date:_____

Name:_____ Birthdate:_____ SS#:_____

Address:_____ City:_____ State_____ Zip_____

Phone Number: (Home)_____ (Cell)_____

_____Minor _____Single _____Married _____Divorced _____Widowed _____Separated

If Student, Name of School/College _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Phone #:_____

Employer Address:_____

Spouse or Parent/Guardian's Name_____ Phone #:_____

Person to Contact in Case of Emergency:_____Phone #:_____

** Who may we thank for referring you?_____

Responsible Party:

Name of Person Responsible for Account:_____ Phone #:_____

Relationship to Patient:_____ Driver's License#_____

Date of Birth:_____ SS#:_____

For Your Convenience, we offer the following methods of payment. Payment is due in full at each appointment.

Cash, Personal Check, Visa, MasterCard (If you would like to discuss financing options please let us know)

Insurance Information: (Please have your insurance card available so that we may obtain a copy)

Name of Insured:_____ Date of Birth:_____SS#_____

Name of Employer:_____ Insurance Carrier:_____

Address:_____ Phone:_____

Policy #:_____

Patient Medical History:

Physician:_____ Phone #:_____ Last Visit:_____

- Are you under medical treatment now?_____
- Have you ever been hospitalized for any surgical operation or serious illness with in the last 5 years? Please explain:

_____

- Please list any and all medications including non-prescription medicine:_____
  _____
  (If you have a list we would be happy to make a copy for your chart)
- Have you ever taken Fen-Phen/Redux?_____
- Have you ever taken Fosmax, Boniva, Actonel or any other caner medications containing bisphosphonates:_____
- Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?_____
- Do you use tobacco? What kind?_____
- Do you use controlled substances?_____
- Do you wear contact lenses?_____

Allergy Information: (Please Circle if you are allergic to or have had any reactions to the following)

Local Anesthetics (e.g. Novocain) Penicillin Other Antibiotics (list)_____ Sulfa Drugs Latex Rubber

Barbiturates Sedatives Iodine Aspirin Any Metals (list)_____ Other (list)_____

Women Only:

a) Are you pregnant or think you may be pregnant? How many weeks?_____
b) Are you Nursing?_____
c) Are you taking oral contraceptives?_____

Major Medical Information:

Please check the box if you have any of the following:

☐	High Blood Pressure	☐	Heart Attack
☐	Rheumatic Fever	☐	Swollen Ankles
☐	Fainting/Seizures	☐	Asthma
☐	Low Blood Pressure	☐	Epilepsy/Convulsions
☐	Leukemia	☐	Diabetes
☐	Kidney Disease	☐	AIDS or HIV Infection
☐	STD's	☐	Hepatitis A, B, or C
☐	Thyroid Problem	☐	Heart Disease

Continued……..

☐	Cardiac Pacemaker	☐	Heart Murmur
☐	Angina	☐	Frequently Tired
☐	Anemia	☐	Emphysema
☐	Cancer	☐	Arthritis
☐	Joint Replacement or Implant	☐	Stomach Troubles/Ulcers
☐	Chest Pains	☐	Easily Winded
☐	Stroke	☐	Hay Fever/Allergies
☐	Tuberculosis	☐	Radiation Therapy
☐	Glaucoma	☐	Recent Weight Loss
☐	Liver Disease	☐	Heart Trouble
☐	Respiratory Problems	☐	Mitral Valve Prolapse
☐	Other_____		

Patient Dental History

Name & Location of Previous Dentist_____ Date of Last Exam_____

Please check the appropriate box:

☐	Glums bleed while brushing and flossing		
☐	Sensitive Teeth Hot/Cold	☐	Pain in Teeth
☐	Sores/Lumps in Mouth or Around	☐	Head/Neck/Jaw Injuries
☐	Frequent Headaches	☐	Clench/Grind Teeth
☐	In Past Difficult Extractions	☐	Prolonged Bleeding w/Extractions
☐	Orthodontic Treatment	☐	Wear Dentures/Partials
☐	Received Hygiene Care and Instructions before		
☐	I Like my Smile! If not what would you like to improve _____		

Do you have any of the following or experienced any of the following with your jaw…….

☐ Clicking/Popping

☐ Pain (joint, ear, side of face) ☐ Difficulty Opening or Closing

☐ Difficulty Chewing

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such Dental Care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment or all services rendered on my behalf or my dependents.

X_____ **Date**_____

Signature of patient (or parent/guardian of minor)