WEST KELLER DENTAL
COSMETIC - FAMILY - IMPLANTS

PATIENT REGISTRATION AND MEDICAL HISTORY

Patient: _____

Home Address: _____City/State/Zip: _____

Sex: M F Date of Birth: _____SS#: _____

Please circle one: Single Married Divorced Widowed **Email Address** _____

Home Phone #: _____ Work Phone #: _____ **Cell Phone #:** _____

Your Occupation: _____ Employer: _____

Parent or Guardian of Minor: _____SS# of Parent: _____

Person Responsible for Payment of Account: _____

Whom may we thank for referring you? _____ **Communication Preference**: TEXT/ EMAIL/ CALL

Ask about our referral program

EMERGENCY INFORMATION: Name: _____ Phone Number: _____

Relationship _____

Dental Insurance Information (Policyholder Information):

Name: _____SS#: _____

Date of Birth: _____ Employer: _____

Employer Address: : _____City/State/Zip: _____

Insurance Company Name: _____

Employer Phone #: _____ Group #: _____

This information is strictly confidential and WILL NOT be released to anyone without your consent. It is important, for your safety that the Doctor knows about your Medical and Dental history. Please make sure this form is accurately completed to the best of your knowledge.

Patient/Guardian Signature: _____Date: _____

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General Medical History:

Acid Reflux	Yes	No	Hepatitis, Any form	Yes	No
Anemia or Blood Disorder	Yes	No	H.I.V. Infection/AIDS or ARC	Yes	No
Arthritis, Rheumatism, other inflammatory disease	Yes	No	Joint Replacement When placed?	Yes	No
Asthma	Yes	No	Kidney Disease	Yes	No
Anticoagulants (Coumadin, Warfarin)	Yes	No	Liver Disease (including Jaundice)	Yes	No
Abnormal Bleeding	Yes	No	Mitral Valve Prolapse	Yes	No
Cancer or Tumor	Yes	No	Sore/Enlarged Lymph Nodes	Yes	No
Diabetes I or II	Yes	No	Osteoporosis	Yes	No
Emphysema or Respiratory/Lung Illness	Yes	No	Pace Maker	Yes	No
Epilepsy/Seizures	Yes	No	Smoking habit – How long/How many?	Yes	No
Hypertension – High Blood Pressure	Yes	No	Psychosis	Yes	No
Fainting or Dizzy Spells	Yes	No	Radiation/Chemo Therapy	Yes	No
Glaucoma	Yes	No	Recurrent Illnesses	Yes	No
Head Injury	Yes	No	Rheumatic Fever	Yes	No
Abnormal Heart or Previous Bacterial Endocarditis	Yes	No	Sinus Problems	Yes	No
Congenital Heart Disease	Yes	No	Slow-Healing Mouth Sores	Yes	No
Heart Valve (artificial) or Heart Transplant	Yes	No	Stomach Problems	Yes	No
Heart Valve Dysfunction	Yes	No	Stroke	Yes	No
Heart Disease, Heart Attack, Heart Surgery	Yes	No	Tuberculosis	Yes	No
Heart Stent – When placed?	Yes	No	Ulcers	Yes	No
Pre-medication before dental treatment?	Yes	No	Unintentional Weight Loss	Yes	No
Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actones, Boniva) If so, when did the treatment begin? When did the treatment end?				Yes	No
Are you under the care of a Physician? If so, Why? Physician's Name: _____Phone #: _____				Yes	No
Have you been hospitalized within the last 5 years? If yes, please explain				Yes	No
Women only: Are you pregnant? Due Date?				Yes	No
If no, are you planning a pregnancy in the near future?				Yes	No
Are you a nursing mother?				Yes	No
Are you taking birth control pills?				Yes	No

List any medications you are currently taking: _____

_____

Have you ever had an allergic or adverse reaction to any of the following?

Local/Topical Anesthetics	Yes	No	Penicillin	Yes	No
Nitrous Oxide	Yes	No	Erythromycin	Yes	No
Iodine	Yes	No	Sulfa	Yes	No
Codeine	Yes	No	Ibuprofen	Yes	No
Latex	Yes	No	Aspirin	Yes	No
Any other allergies?				Yes	No

Patient/Guardian Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

West Keller Dental, PLLC

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Insurance Consent

As a courtesy, West Keller Dental will file your insurance claim and assist in collecting from the insurance company. However, West Keller Dental does not render services on the assumption that our charges will be paid by the insurance company. The "patient portion" *is only an estimate,* and in the event that the insurance company pays less than the estimated amount, **you are responsible for the unpaid portion.**

We would also like to inform you that most (but not all) insurance companies allow the benefit of amalgam (silver/mercury) fillings instead of composite fillings (tooth colored) and the benefit of full cast crown (metal/gold) instead of porcelain fused to high noble metal crowns on posterior (back) teeth. The cost difference between the two is usually minimal but please be aware, **You will be responsible for the amount that your insurance does not cover.** Please ask any member of our staff to see which benefit your insurance covers and advise them if you would rather have the amalgam fillings or the full cast crown.

Patient/Guardian Signature: _____

Date: _____

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed of your *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your *Notice of Privacy Practices* prior to signing this consent. I understand that *West Keller Dental* has the right to change its *Notice of Privacy Practices* from time to time and that I may contact *West Keller Dental* to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I authorize the Doctor and his staff to contact me by Phone__ Email__ Mail__(check all that apply)

Patient/ Name: _____

Patient/Guardian Signature: _____

Relationship to Patient: _____ __Date_____

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Broken Appointment Agreement

We pride ourselves in providing extra time for the personal attention each patient deserves. We respect your time and make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you. To be consistent with this, we have this Broken Appointment Agreement.

Our end of this agreement:

We agree to respect your time.

Your end of the agreement:

You agree to give us 48 hours' notice if you need to change your appointment. If you do not give this amount of notice you may be charged a $50.00 broken appointment fee, this will be deducted from any deposit made for the appointment or charged to you via a statement.

How to change your appointment

To change your appointment, please call 817-431-5953 to speak to a member of our team.

We value you as a patient and look forward to a long respectful relationship.

I, _____ (print name), have received a copy of West Keller Dental's broken agreement and agree to its terms.

_____

Signature of Patient/Guardian Date

Billing Fee Agreement

I, _____ (print name), agree that if my account ages past 60 days a $5.00 billing fee will be applied monthly to my account until the account has a $0 balance.

_____

Patient/Guardian Date

West Keller Dental, PLLC