

JEFFREY F. WEST, DDS, MD

MEDICAL HISTORY

Patient Name _____ Date _____

1. My last physical exam was on _____ Height _____ Weight _____
2. Are you under the care of a physician? YES NO
3. The name & phone number of my physician _____
4. Have you had any serious illness, operation or hospitalization within the past 5 years YES NO
If so, What? _____
5. Are you taking ANY medications including prescription, non-prescription, vitamins and herbal medications (including aspirin & blood thinners)? YES NO
If so, What? _____

6. Do you have or have you had any of the following diseases or problems?

Damaged Heart Valves, Artificial Valves or Heart Murmur.....	YES	NO
Rheumatic Heart Disease.....	YES	NO
Heart Trouble, Heart Attack or Stroke.....	YES	NO
High Blood Pressure.....	YES	NO
Shortness of Breath, Chest Pains.....	YES	NO
Have you ever been told to Pre-Medicate?.....	YES	NO
Allergies.....	YES	NO
If so, What? _____		
Sinus Trouble.....	YES	NO
Asthma or Hay Fever.....	YES	NO
Fainting Spells or Seizures.....	YES	NO
Diabetes.....	YES	NO
Hepatitis, Jaundice or Liver Disease.....	YES	NO
Thyroid Problems.....	YES	NO
Respiratory Problems or Emphysema.....	YES	NO
Arthritis or Swollen Joints.....	YES	NO
Ulcers or Stomach Trouble.....	YES	NO
Kidney Trouble.....	YES	NO
Tuberculosis.....	YES	NO
Persistent Cough or Cough the Produces Blood.....	YES	NO
Persistent Swollen Neck Glands.....	YES	NO
Epilepsy or Neurological Disorder.....	YES	NO
Problems with Mental Health.....	YES	NO

MEDICAL HISTORY

JEFFREY F. WEST, DDS, MD MEDICAL HISTORY

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| 6. | Continued | | |
| | Cancer..... | YES | NO |
| | Radiation Treatment or Chemo Therapy..... | YES | NO |
| | Problems with Immune System..... | YES | NO |
| | HIV or AIDS..... | YES | NO |
| | Anemia..... | YES | NO |
| | Glaucoma..... | YES | NO |
| 7. | Have you ever had treatment for a tumor or growth..... | YES | NO |
| 8. | Are you allergic or have you had a reaction to | | |
| | Local Anesthetics..... | YES | NO |
| | Penicillin or Antibiotics..... | YES | NO |
| | Sulfur Drugs..... | YES | NO |
| | Barbiturates or Sleeping Pills..... | YES | NO |
| | Aspirin..... | YES | NO |
| | Iodine..... | YES | NO |
| | Codeine..... | YES | NO |
| | Other..... | YES | NO |
| 9. | Have you had any serious trouble associated with previous medical or dental Treatment? If so, Explain _____ | YES | NO |
| 10. | Do you have any other condition or disease you think we should know about If so, Explain _____ | YES | NO |
| 11. | Are you wearing Contact Lenses..... | YES | NO |
| 12. | Are you wearing Removable Dental Appliances..... | YES | NO |
| 13. | Are you Allergic to Dental Anesthetic..... | YES | NO |
| 14. | Are you aware of a recent Weight Change..... | YES | NO |
| 15. | Are you subject to Frequent Urination..... | YES | NO |
| 16. | Are you Often Thirsty..... | YES | NO |
| 17. | Are you Often Exhausted or Fatigued..... | YES | NO |
| 18. | Are you subject to Frequent Headaches..... | YES | NO |
| 19. | Are you Excessively Nervous..... | YES | NO |
| 20. | Are you in Good Health now..... | YES | NO |
| 21. | Do you Smoke..... | YES | NO |
| | If so, How much? _____ | | |
| 23. | Does anyone in your family have diabetes..... | YES | NO |
| 24. | Do you have Prolonged Bleeding after Injury or Tooth Extraction..... | YES | NO |
| | <u>WOMEN</u> | | |
| 25. | Are you Pregnant..... | YES | NO |
| 26. | Presently in Menopause..... | YES | NO |
| 27. | Do you have problems associated with your Menstrual Cycle..... | YES | NO |
| 28. | Are you taking Birth Control (Pills, Patch or Shot)..... | YES | NO |

JEFFERY F. WEST, DDS, MD
DENTAL HISTORY

Patient Name _____ Date _____

1. My last Professional Cleaning _____
2. Frequency of Brushing _____
3. Type of Toothbrush (Hard, Soft or Electric) _____
4. Other Dental Aid (Floss, Toothpick...) _____
5. Frequency or Dental Visits _____
6. Do you have or have you had any of the following diseases or problems?

Mouth Breathing.....	YES	NO
Bleeding Gums.....	YES	NO
Trench Mouth.....	YES	NO
Pyorrhea.....	YES	NO
Grinding Teeth.....	YES	NO
Clenching.....	YES	NO
Shifting Teeth.....	YES	NO
Loose Teeth.....	YES	NO
Receding Gums.....	YES	NO
Halitosis (Bad Breath).....	YES	NO
Past Periodontal Treatment.....	YES	NO
If yes, who? _____		
Past Orthodontic Treatment.....	YES	NO
If yes, who? _____		
7. Chief Dental Concern _____
8. In your opinion, what is your general dental condition? _____

9. Are you conscious of your teeth in any way? _____
10. Are you satisfied with the way they look? _____
11. Do you drink two or more cups of coffee per day? _____
12. Do you eat more than one snack a day? _____
13. What is your usual snack? _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Responsible Person, if not patient, Relationship to Patient _____ Date _____

Signature of Doctor _____ Date _____

JEFFREY F. WEST, DDS, MD

INSURANCE INFORMATION

We will gladly file your primary dental insurance for you. After your primary insurance has paid, we will be happy to file any secondary insurance for you. Please note you are responsible for any balance not paid by your insurance carrier. In order for us to file your claims we must make a copy of your insurance card. Please notify our office if you have any changes in your insurance coverage.

Primary Insured Information

Name _____ Date of Birth _____ Soc. Sec# _____

Address _____ Relation To Patient: Self ____ Spouse ____ Child ____ Other ____

City _____ State _____ Zip Code _____

Insured Employer _____ Work Phone _____

Employer Address _____

PRIMARY INSURANCE: Name of Carrier _____

Address _____

Phone _____ Group # _____ Insured ID# _____

Secondary Insured Information

Name _____ Date of Birth _____ Soc. Sec# _____

Address _____ Relation To Patient: Self ____ Spouse ____ Child ____ Other ____

City _____ State _____ Zip Code _____

Insured Employer _____ Work Phone _____

Employer Address _____

SECONDARY INSURANCE: Name of Carrier _____

Address _____

Phone _____ Group # _____ Insured ID# _____

I hereby authorize Jeffrey F. West, DDS, PA to release to my insurance company information acquired in the course of my dental care. I understand I am responsible for full payment of all charges incurred on my account regardless of expected insurance benefits

Signature of Person Responsible for Account

Date

JEFFREY F. WEST, DDS, MD
ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

- Obtain payment from third-party payers for my health care services

- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name

Date

Signature of Responsible Person

If not patient, Relationship to Patient

Dependent family members also covered by this acknowledgement

JEFFREY F. WEST, DDS, MD

FINANCIAL POLICY

Thank you for choosing our office. We are committed to your treatment being successful. Please understand payment of your bill is considered a part of your treatment. By having a financial policy we are better able to control our administrative costs. Please read and sign prior to any services being rendered. Let us know if you have any questions.

As a courtesy to our patients, we will gladly file your insurance for you. The total charge for your care is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us correct insurance information and allow us to copy your insurance card. We accept assignment of benefits, which will enable your insurance company to pay our doctor directly.

As a courtesy we will provide the following services to you:

- Filing claims for services rendered with your insurance company.
- Research your dental insurance plan and advise you of estimated benefits available to you.
- Re-file claims for services within 60 days, if there has been no response from the insurance company.
- Follow the American Dental Association guidelines for coding procedures and filling insurance claims.

Our expectations of you as the owner of the insurance policy:

- Understanding that the insurance is a contract between **You, your Employer & the Insurance Company.** We have no leverage to obtain payment from your insurance company.
- Realizing that dental insurance policies restrict payment for some procedures based on prior schedules (called Usual and Customary) and exclude some procedures based on prior conditions or length of time enrolled in the plan. All restrictions are based on the PREMIUM PAID FOR THE POLICY, not on our fees or recommended treatment.
- Keeping our office informed of any changes in your insurance coverage (new employment, business changes insurance company, ect.)
- Should you feel you have been treated unfairly by your insurance company, we recommended that you communicate with the North Carolina Insurance Commissioner- Jim Long 919-733-6212

We must emphasize that as dental provider, our relationship is with you, our patient, and not your insurance company. While the filing of claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the service is rendered.

CASH, CHECKS, ALL MAJOR CREDIT CARDS AS WELL AS CARE CREDIT ARE ACCEPTED BY OUR OFFICE. Finance charges begin to accrue at 90 days at the rate of 1.5% per month (18% per year). Any charges incurred to collect and during collection will be added to the balance due. Our office charges a \$30.00 fee for all checks returned from your bank due to insufficient funds.

APPOINTMENT CANCELLATION POLICY

Please help us provide treatment to all our patients by keeping your scheduled appointments. We require a minimum 24-hour notice for cancellation of appointments. If an appointment is missed or not cancelled within 24 hours there will be a \$75.00 fee.

Thank you for taking the time to read our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy

Signature of person Responsible for Account

Date