WESTLAKE SMILE DESIGN

Welcome to Westlake Smile Design

PATIENT INFORMATION

Date_____Home Phone (_____)_____Cell Phone (_____)_____Work (_____)_____

Name _____Social Security #_____

Address_____E-mail_____

City_____State_____Zip_____

Sex ☐M ☐F Age_____Birthdate_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for____years

Patient Employer/School_____Occupation_____

Employer/School Address_____Employer/School Phone (_____)_____

Whom may we thank for referring you?_____

In case of emergency who should be notified_____ Relationship_____Phone (_____)_____

PRIMARY INSURANCE

Person responsible for account_____

Relation to patient_____Birthdate_____ID#/Soc. Sec. #_____

Address (if different from patient's)_____Phone (_____)_____

City_____State_____Zip_____

Person responsible employed By_____Occupation_____

Business Address_____Business Phone (_____)_____

Insurance Company_____

Contact #_____Group #_____Subscriber #_____

Names of other dependants covered under this plan_____

I certify that I, and/or my dependant(s), have insurance coverage with_____and assign directly to Dr. David Hakimi and Dr. Armon Eben all insurance benefits. I understand that I am financially responsible for all charges whether or not paid for by insurance. I authorize the use of my signature and any of my other information on all insurance submissions. I understand that payment is due in full at the time of the treatment.

Print name	Signature	Relationship to Patient	Date

DENTAL HISTORY

Reason for today's visit_____ Date of last dental care_____

Reason for leaving former dentist_____ Date of last dental x-rays_____

Please mark "yes" or "no" for the following:

Dry mouth	☐ yes ☐ no	Grinding teeth	☐ yes ☐ no	Sensitivity to hot	☐ yes ☐ no
Bad breath	☐ yes ☐ no	Clenching teeth	☐ yes ☐ no	Sensitivity to cold	☐ yes ☐ no
Mouth breathing	☐ yes ☐ no	Clicking or popping jaw	☐ yes ☐ no	Sensitivity to sweets	☐ yes ☐ no
Swollen or tender gums	☐ yes ☐ no	Jaw pain or tiredness	☐ yes ☐ no	Sensitivity when biting	☐ yes ☐ no
Bleeding gums	☐ yes ☐ no	Broken fillings	☐ yes ☐ no	Past need for root canal	☐ yes ☐ no
Loose teeth	☐ yes ☐ no	Mercury "silver" fillings	☐ yes ☐ no	Past orthodontic treatment	☐ yes ☐ no
Past periodontal treatment	☐ yes ☐ no	Food collection between teeth	☐ yes ☐ no	Sores/growths in your mouth	☐ yes ☐ no

How often do you floss?_____ How often do you brush?_____