"A Better Life Starts With A Beautiful Smile"

Name_____ Home Phone# (_____) _____Cell (_____) _____

Address_____ Apt# _____City_____ State _____ Zip Code _____

Date of Birth _____/_____/_____ Age: ___ Sex: M/F Marital Status: Married /Single Social Security No. _____-_____-_____

Employer _____Occupation_____ Office Phone# (_____) _____

Email: _____

Emergency Contact Information

Name_____ Relationship_____ Home Phone# (____) _____Cell (____) _____

Email: _____ Pharmacy_____

Who May We Thank for Referring You _____

For the following questions, circle yes or no, whichever applies? Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
   If so, explain? _____
3. Have you had a physical examination within the last past year? ..... Yes No
   If so, when was your last physical examination? .....
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. The name and address of my physician(s) is _____
6. Do you wake up with headaches? ..... Yes No
7. Do you have a CPAP? (Continuous positive airway pressure) ..... Yes No
8. Have you ever been diagnosed with Sleep Apnea? ..... Yes No
9. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
   If so, explain? _____
10. Are you taking any type of medication(s) including non-prescribed medication(s)? ..... Yes No
    If so, what medication(s) are you taking _____
11. Do you have or have you had any of the following diseases or problems? .....
    a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease. Yes No
    b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure/low blood pressure, arteriosclerosis, stroke) ..... Yes No
        1. Do you have chest pain upon exertion? ..... Yes No
        2. Do you have inborn heart defects? ..... Yes No
        3. Do you have a cardiac pacemaker? ..... Yes No
    c. Sinus trouble ..... Yes No
    d. Asthma, Hay Fever, or Bronchitis ..... Yes No

e. Fainting spells, Seizures, Epilepsy ……. Yes No
f. Diabetes …….. Yes No
g. Hepatitis, Jaundice, or Liver disease…… Yes No
h. AIDS or HIV infection …… Yes No
i. Thyroid Problems …… Yes No
j. Arthritis or painful swollen joints …… Yes No
k. Kidney trouble ……. Yes No
l. Tuberculosis …… Yes No
m. Persistent swollen glands in the neck ……. Yes No
n. Psychiatric problem …… Yes No
o. Cancer ……. Yes No

If so, what type of cancer? _____

12. Do you have any blood disorders such as anemia? ……. Yes No
13. Are you allergic or have you had a reaction to ……... Yes No
    a. Local Anesthetic ……... Yes No
    b. Penicillin or other antibiotics ……..... Yes No
    c. Barbiturates, sedatives, or sleeping pills …… Yes No
    d. Aspirin …….. Yes No
    e. Iodine …… Yes No
    f. Codeine or other narcotics …… Yes No
    g. Latex ……. Yes No
    h. Other _____
14. Have you had any serious trouble associated with any previous dental treatment? …….. Yes No
    If so, explain _____
15. Do you have any disease, condition, or problem not listed above that you think we should know about….. Yes No
    If so, explain _____
16. Do you currently use any type of tobacco of any type? …… Yes No
    If so, which type? _____

Women

17. Are you pregnant? …… Yes No
18. Are you nursing? …….. Yes No
19. Are you taking birth control pills? …… Yes No

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian _____ Date _____

WESTLAKE
FAMILY DENTISTRY

COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant to statements from the Center for Disease Control (CDC) and the American Dental Association (ADA), nonessential or elective treatment, based on the assessment of our staff, will be rescheduled. According to the ADA, dental emergencies are “potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection.” The ADA also recommends that urgent dental care which “focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments” be provided in as minimally invasive a manner as possible.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I further confirm I am seeking treatment for a condition that meets the emergent or urgent criteria noted above. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

_____	_____	_____
Signature	Witness	Date

WESTLAKE
FAMILY DENTISTRY

"A Better Life Starts With A Beautiful Smile"

Informed Consent
General Consent for Dental Cleaning

I understand I am in the office today for my continuing care appointment. My treatment MAY include the following procedures:

Prophylaxis, Periodontal Maintenance, Gross Debridement, X-Rays, Fluoride treatment, Bio screen Oral Cancer Screening and/or Dental Exam.

I understand that all dental procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Swelling, bleeding, sensitivity, or pain

I understand the recommended treatment for my conditions, the risk of such treatment, any alternatives and risk, as well as the consequences of doing nothing. I also understand that my insurance may not pay all procedures. Any fees involved have been explained. All of my questions have been answered, and I have not been offered any guarantees.

Date _____

Patient Name_____

Signature_____

Patient/ Parent/ Guardian

Notice of Privacy Policy

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your information may be disclosed to other healthcare providers for the purpose of providing you with a continuum of quality healthcare.
- Your confidential healthcare information may be disclosed to your insurance provider for the purpose of receiving payment for providing healthcare services.
- Your confidential healthcare information may be disclosed to public officials or law enforcement agencies in an investigation in which you are the victim of abuse, a crime, or domestic violence.
- Your healthcare information may not be disclosed for purpose other than those, which are outlined in this notice.
- Your confidential healthcare information may only be disclosed after receiving written authorization from you. You have the right to revoke your permission to disclose confidential information at any time.
- You may be contacted by personnel to remind you of an appointment, healthcare treatment option or other health services that may be of interest to you.
- You have the right to restrict the use and disclosure of your confidential healthcare information to family members, friends and other involved in your healthcare plan or payment for the health care services. However, the dental office may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the evet of a medical emergency.
- You have the right to receive confidential communication about your healthcare status.
- You have the right to review and request a copy of any and/or all portions of our healthcare information.
- You have the right to request changes be made to your healthcare information and for what reason.
- You have the right to know who has obtained your confidential healthcare information and for what reason.
- You have the right to have a copy of this privacy notice upon request.
- The dental office is required by law to protect the privacy of its patients.
- The dental office will abide by the terms of this notice. We reserve the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- You have the right to complain to the privacy officer of this office and to the office of the Secretary of Health and Human Services if you believe your rights to privacy have been violated. If you feel your privacy right have been violated, please mail complaint to: ATTN: Privacy officer, Westlake Family Dentistry, 3000 W Alton Gloor Ste D, Brownsville, TX 78520.
- All complaints will be investigated. No personal issues will be raised for filling a complaint with the dental office.
- For further information about this Privacy Notice, please contact the Privacy Officer at (956) 312-0284.

ACKNOWLEDGEMENT OF RECEIPT

I_____have reviewed a copy of Notice of Privacy Policy provided by Westlake Family Dentistry. * **I can get a copy of this notice upon request.**

Signature_____**Date**_____

Patient, Parent/Legal Guardian

Financial Policy

Thank you for choosing Westlake Family Dentistry Clinic for your dental needs. In an effort to provide quality care to our patients and to avoid misunderstandings, we would like to inform you of our office policy regarding payment for services rendered.

_____ Full payment is expected at the time dental treatment is performed. As a courtesy to our patients with dental benefits, we will submit your insurance claim to your insurance company. Any portion not expected to be covered by these benefits is the responsibility of the patient and due at the time service is rendered. This amount will include deductibles and co-payments. If benefit amounts are less than expected, you will be billed for the difference and payment is due within 10 days.

_____ Dental benefits are contracts between the policyholder and the insurance company, not our office. We will make every effort to assist you with any benefit questions, however we suggest that you may be aware of what benefits you have available. Your insurance makes the final decision on what they will pay for each claim, in some cases giving an alternate benefit or not paying for a procedure at all. Ultimately, you are responsible for the balance, downgrades or underpayment.

_____ Marital status is not a consideration under any circumstance. Decreed custody or lack thereof, does not alter financial responsibility. The parent accompanying the child/minor on the day of service will be considered the responsibly party. We gladly provide you the copies of statements, which you may need to provide the other parent for reimbursement.

_____ There is a $35.00 charge for any returned check. If a check is not returned and not paid within 5 days of returned date, illegal actions may be taken for collection. Any cost associated with collection of returned check will be assumed by you.

_____In the event your account becomes delinquent, you agree to reimburse us the fees of any collections agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts.

_____ A 50 % deposit is required to **RESERVE** your appointment with the Dentist. The remaining 50% is due at the time of your scheduled appointment.

_____ For your convenience, we accept: Cash, Check, Visa, Master Card, Discover and CareCredit.

Broken Appointment Policy
Westlake requires 24 hours for cancellation or rescheduling of an appointment.
If 24 hours is not given, a $50.00 broken appointment will be charged.

By signing below, you understand and accept the terms of our Financial Policy.

Signature of Responsible Party _____Date_____
*Patient, Parent /Legal Guardian

Photo Consent

I, _____ grant permission to **Westlake Family Dentistry** for the use of the photograph(s) or electronic media images as identified below in any presentation of any and all kind whatsoever. I understand that I may revoke this authorization at any time by notifying **Westlake Family Dentistry** in writing. The revocation will not affect any actions taken before the receipt of this written notification. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time destroyed or archived.

Image(s) description: photos / videos

Date_____

Patient/Legal Guardian Name _____

Signature _____