



**Patient Dental History** Name: \_\_\_\_\_

Westlake Family Dentistry

What is your primary reason for your visit today? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ Name of previous dentist: \_\_\_\_\_

Have your previous dental experiences been favorable? \_\_\_\_\_ If not, please explain: \_\_\_\_\_

Reason for changing dentists: \_\_\_\_\_

<b>Have you experienced any of the following:</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Sensitivity to hot or cold.....	<input type="checkbox"/>	<input type="checkbox"/>	Does food catch between your teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to sweets or sour.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to pressure/biting.....	<input type="checkbox"/>	<input type="checkbox"/>	Habitual grinding or clenching of teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums while brushing/flossing.....	<input type="checkbox"/>	<input type="checkbox"/>	Jaw joint pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequently bite cheeks/lips.....	<input type="checkbox"/>	<input type="checkbox"/>	Clicking or popping of jaw.....	<input type="checkbox"/>	<input type="checkbox"/>
Sores or lumps in or around your mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	Pain in ear or side of face.....	<input type="checkbox"/>	<input type="checkbox"/>
Gum recession.....	<input type="checkbox"/>	<input type="checkbox"/>	Crooked teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal (gum) treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Cracked or broken teeth.....	<input type="checkbox"/>	<input type="checkbox"/>	Discolored teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficult extractions.....	<input type="checkbox"/>	<input type="checkbox"/>	Root canal treatment.....	<input type="checkbox"/>	<input type="checkbox"/>

**Medical History**

This information will help us in preventing serious medical complications. Please let us know if there is anything not listed, that you feel we should know about, in regards to your medical/dental health.

Name of Physician: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Are you under medical treatment now? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

Have you been hospitalized or had a serious illness in the last 3 years? \_\_\_\_\_ Explain: \_\_\_\_\_

Do you smoke or use smokeless tobacco? \_\_\_\_\_ If yes, how often? \_\_\_\_\_ How many years? \_\_\_\_\_

<b>If taking any medications, including non prescription medicine? Please list:</b>	<b>Do you have or ever have had any of the following:</b>	<b>Y</b>	<b>N</b>		<b>Y</b>	<b>N</b>
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_____	Aids/HIV.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
_____	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>
_____	Angina/Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
_____	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>
_____	Artificial joint/Implant...	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure..	<input type="checkbox"/>	<input type="checkbox"/>
_____	Asthma/resp. problems...	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Allergies or reactions to:</b>	Bleeding problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics.....	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics.....	Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates.....	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives.....	Dizziness/Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care.....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin.....	Easily Winded.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach issues/ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Latex.....	Epilepsy/Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs.....	Emphysema/COPD.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	Glaucoma/Cataracts.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Women: Are you pregnant?</b>	Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

\*I certify that I have read and understand the above information and have answered truthfully to the best of my knowledge. I understand that providing incorrect information can be dangerous to my medical/dental health.

**Printed name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Personalized Smile Evaluation

Please take a moment to look at your teeth and gums carefully  
and then answer the following questions:

1. On a scale of 1 to 10, how do you feel about your teeth and smile? \_\_\_\_\_  
\_\_\_\_\_
2. Are your teeth crooked or crowded? Is this a concern? Please comment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Do you have any spaces between your teeth that bother you? \_\_\_\_\_  
\_\_\_\_\_
4. Do you like the color of your teeth? Please comment: \_\_\_\_\_  
\_\_\_\_\_
5. Do you like the shape of your teeth? Please comment: \_\_\_\_\_  
\_\_\_\_\_
6. What would you like to change about the appearance of your smile? \_\_\_\_\_  
\_\_\_\_\_
7. Have you ever considered how you might feel or how your personal and/or professional life might be affected with a brighter smile? Please comment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Financial Arrangements & Dental Insurance**

We are committed to providing you with the best possible care. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment protocol.

**Payment for treatment is due at the time services are rendered** unless payment arrangements have been approved in advance by our financial coordinator. We accept cash, checks, Visa and MasterCard. As a patient you are fully responsible for all fees for services rendered. As a courtesy we file your insurance claims for you. We also accept payments directly from your primary insurance carrier in order to help you simplify the insurance process. If your insurance does not pay any portion of your bill you will be billed accordingly and are fully responsible for any outstanding balance. If you have secondary insurance we will be happy to bill them for you.

Returned checks are subject to a \$30 charge and balances older than 30 days may be subject to interest charges of 1.5% per month or 18% per annum.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

**Please understand that:**

1. Your insurance is a contract between you, your employer and the insurance company.
2. Dental insurance policies restrict payment for some services. They use restricted fee schedules (called "UCR") and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, *NOT* our fees or recommended treatment. Some insurance companies arbitrarily select certain services they will not cover.

As dental care providers, we must emphasize that our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

**We require 48 hours notice for cancellations or rescheduling. Appointments canceled or rescheduled without 48 hours notice and missed appointments may incur a \$100 fee.**

If you have any questions about the above information or any uncertainty regarding your insurance coverage, please don't hesitate to ask us. We are here to help.

**I understand that Westlake Family Dentistry will make every effort to give accurate insurance benefit quotes for my treatment however I am responsible for any portion not covered by my insurance company. I have read, understand and agree to abide by the above financial policy.**

Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Acknowledgement of Receipt of  
Privacy Policy Notice**

I, \_\_\_\_\_,  
have received a copy of this office's PRIVACY POLICY NOTICE.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our PRIVACY POLICY NOTICE, but acknowledgement could not be obtained because:

\_\_\_\_\_ Individual refused to sign

\_\_\_\_\_ Communications barriers prevented obtaining the acknowledgement

\_\_\_\_\_ OTHER: \_\_\_\_\_

**Privacy Policy Notice**

This Notice describes how health information about you may be used and disclosed and how you can get access to this information.

**PLEASE REVIEW CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT.**

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new items of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

**Treatment:** We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations.

Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities.

**Your authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Persons Involved In Care:** We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment and disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar form of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody or protected health information of inmates or patients under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards and letters).

## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address listed at the end of this Notice. If you request copies, we will charge you \$.10 for each page, \$10.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes , other than treatment, payment, healthcare operation and certain other activities, for the past 6 years, but not from before April 14, 2003. If you request this accounting more than once in a 12 month period, we will charge you a reasonable cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may discuss this with us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**If you have any questions or concerns regarding this Notice, please contact us at:**

Westlake Family Dentistry  
Dr. Bradley E. Sievert  
16016 Boones Ferry Rd. St. 100  
Lake Oswego, OR 97035  
503.636.4576  
Fax: 503.697.5069