West Family Dentistry

2955 N Moorpark Rd #B
Thousand Oaks, CA 91360
Ph: (805) - 492-5050
Fax: (805) - 436-1217
www.westfamilydentistry.net

Chart #: _____
FOR OFFICE USE ONLY

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Sex: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____ Best time to call: _____

E-mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Referred by: _____

May we send text messages to your cell phone for reminders and updates? ☐Yes ☐No

PERSON TO CONTACT IN CASE OF AN EMERGENCY

Outside of Immediate Family/Household:
Name: _____
Address: _____
City/State/ZIP: _____
Telephone #: _____

HEALTH INFORMATION

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies
☐ Anemia
☐ Angina/Chest Pain
☐ Arthritis
☐ Artificial Joints
☐ * Artificial Heart Valve
☐ Asthma
☐ Bacterial Endocarditis
☐ Blood Disease
☐ Blood Transfusion
☐ Bloody Sputum
☐ Cancer
☐ Chemotherapy
☐ Congenital Heart Disorder
☐ Cortisone Medicine
☐ Convulsions
☐ Diabetes
☐ Dizziness
☐ Drug Addiction
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Fever Blisters/ Cold Sores
☐ Frequent Diarrhea
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Attack
☐ Heart Disease
☐ * Heart Murmur
☐ * Heart Surgery
☐ Hepatitis A
☐ Hepatitis B or C
☐ High Blood Pressure
☐ Hypoglycemia
☐ Irregular Heart Beat
☐ Jaundice
☐ Kidney Disease
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mental Disorders
☐ * Mitral Valve Prolapse
☐ Nervous Disorders
☐ Night Sweats
☐ * Pacemaker
☐ Pain In Jaw Joints
☐ Phen Phen
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Respiratory Problems
☐ * Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Sickle Cell Disease
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tattoos/Body Piercings
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Unexplained Fever
☐ Venereal Disease
☐ Other:
_____
_____

Are you allergic to any medications or substances? Please check box below:
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other_____

(*) May require pre-medication prescribed by patients Dentist/ M.D.

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MEDICAL HISTORY

Have you ever had any other serious illness not listed above? ☐ Yes ☐ No
If yes, please explain: _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Have you been admitted to a hospital, had a major operation or needed emergency care during the past two years?
☐ Yes ☐ No
If yes, please explain: _____

Have you ever had a serious injury to your head or neck? ☐ Yes ☐ No
If yes, please explain: _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No
If yes, please explain: _____
WOMEN (please check) ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives
Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Name of Physician: _____ Phone: _____
Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:_____

DENTAL HISTORY

Do you have a specific dental problem? ☐ Yes ☐ No
If yes, please explain: _____
Do you have dental examinations on a routine basis? ☐ Yes ☐ No
Last visit?_____
Do you think you have active decay or gum disease? ☐ Yes ☐ No
Do you brush and floss on a routine basis? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No
Do you like your smile? ☐ Yes ☐ No
If no, please explain:_____
Does food catch between your teeth or are there any loose teeth? ☐ Yes ☐ No
Do you want to keep your remaining teeth? ☐ Yes ☐ No
Do you ever have clicking, popping or discomfort in the jaw joint? ☐ Yes ☐ No
Do you ever brux or grind your teeth? ☐ Yes ☐ No
Have your past experiences in a dental office always been positive? ☐ Yes ☐ No
Do you smoke or chew? ☐ Yes ☐ No
Any sores or growths in your mouth? ☐ Yes ☐ No
If yes, please explain: _____
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Do you wish to talk to the dentist privately about any problems? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____Initials:_____
Signature of patient, parent or guardian

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: ☐ the patient ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

Sex: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

INSURANCE INFORMATION

Primary

Dental Insurance Co. : _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ SS #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Dental Insurance Co. : _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐ Another patient [Friend Or Relative]

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Initials: _____

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CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____ Initials: _____
Signature of guarantor of payment/responsible party

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AUTHORIZATION

☐ I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my insurance benefits.

☐ I authorize release of any information relating to my dental claims.

X_____ _____
Signed (patient OR parent if a minor) Date

☐ I assign dental benefit payments to be paid directly to Dr. Roger West, Dr. Vanessa West, or West Family Dentistry, from my insurance company.

X_____ _____
Signed (patient OR parent if a minor) Date

☐ I give my permission for my dentist and his/her clinical team to take any necessary x-rays, photos or study models to enable complete diagnosis and treatment.

X_____ _____
Signed (patient OR parent if a minor) Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 April 14, 2003, 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 terms 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 new 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 or 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, conducting 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 written authorization, we cannot use or disclose your health information for any reason except those described in this 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.

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 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 forms of health information.

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

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

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, or 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.

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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or 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 practicably 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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 operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: 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 complain to 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.

Contact Officer: Roger West`
Telephone: 805-492-5050
Fax: 805-436-1217
E-Mail: info@westfamilydentistry.net
Address: 2955 N Moorpark Rd #B
Thousand Oaks, CA 91360

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I,_____ , have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign

_____Communications barrier prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)_____

_____

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I, (print name)_____, hereby authorize Dr. Roger West, D.D.S. , and/or associates to take photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, professional publications, & on the internet.

I further understand that if the photographs, slides, and/or videos are used in any publication, or as part of a demonstration, all reasonable attempts will be made to conceal my identity.

_____ _____
Patient's Signature If a Minor, Signature of Parent or Guardian

_____ _____
Witness Signature Doctor's Signature

_____
Date

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Welcome to West Family Dentistry!

We would first like to thank you for choosing our office to fulfill all of your dental needs.

Please understand that having dental insurance coverage is not a guarantee of payment. It is in your best interest and responsibility to know your dental policy. As an office we do our best to accurately estimate what your coverage and payments will be. We will provide your insurance company with any and all necessary materials to process your dental claims. Any questions regarding any E.O.B.'s (Explanation of Benefits) received from your insurance company need to be directed towards your insurance company. Any treatment not covered by your insurance company is due in full by you. We will be glad to assist in any way to help get your insurance to pay on your dental claims.

If for some reason your account becomes past due, the undersigned also agrees to pay all collection costs incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance should any unpaid balance be referred to a collection agency. In addition should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the Court.

If unable to keep an appointment, please give at least 24 hours notice. All appointments are important to us and we wish to schedule everyone at their earliest convenience. Although it is the patients' responsibility to remember appointments that were made, we do call to confirm all appointments at least a day in advance. We ask that you call back to confirm your appointment so that we know you will be coming for your appointment. We reserve the right to charge $35.00 for any and all missed appointments. Please help us keep our records up to date, by informing us of any changes in your address, phone numbers, or insurance.

We make every attempt to seat you at your scheduled time, however, unforeseen emergencies can & do arise. Please be patient & understanding, as you might someday be in the same situation.

Welcome to the Practice! From all of us at West Family Dentistry!

I have read the above statements and understand that these are the office policy's for West Family Dentistry

Signed_____ Date_____

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GENERAL CONSENT

Name:_____ **Date:**_____

Drugs, medication and sedation:

I have been informed and understand that antibiotics, analgestes and other medication can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (sever allergic reaction) and they can cause pain, thrombophiebitis (inflammation of a vein) from intravenous and intramuscular injections, injury to and stiffening of neck and facial muscles. They may cause drowsiness and lack of awareness and coordination that can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects f the anaesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued r aggravated infection and pain and potential resistance to effective treatment for my condition.

By signing this, you are giving the practitioner the permission to prescribe needed medications and to give anaesthetics necessary for your dental care. You are also informed of all possible risks associated with the use of anaesthesia or medication. (Initials_____)

Concerning your treatment plan:

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I also understand that I will be able to approve all new treatment beforehand. I therefore give my permission to the Dentist to make any and all changes and additions when nexessary, the cost of which is my responsibility. (Initials_____)

Removal of teeth:

I authorize my Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #2. I understand removing teeth des not always remove all the infection, if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, prolonged bleeding, breakage of adjacent teeth, fractured jaw, loss of feeling in adjacent teeth, lips, tongue and surrounding tissue (parasthesia) that can last for an indefinite period of time. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (Intials_____)

Crowns, Bridges and Implants:

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. It is necessary for crown cementation to be completed in a timely manner, otherwise, it may be necessary to do additional laboratory procedures, the cost of which is my responsibility. I realize that the final opportunity to make changes in my new crown or bridge, (including shape, fit, size and color) will be before cementation procedures. (Initials_____)

Complete or Partial Dentures

I realize that full or partial dentures are artificial, thermo-plastic and/or metal, made with acrylic or porcelain teeth. I also realize that full or partial dentures are merely substitute and will never feel the same, or be the same, as natural teeth. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage due to misuse in handling and normal wear and tear or accident the cost of which is my responsibility. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement and color) will be the “teeth in wax” try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. If an immediate denture-partial is desired, which is an option, if teeth are being extracted, the additional cost will be my responsibility. (Initials_____)

(continued on back page)

Endodontic Treatment (Root Canals)

I realize that there is no guarantee that root canal treatment will save my tooth. I also understand that complications may occur (i.e. broken files or instruments) which may or may not affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (aspicoectomy) and that it may be necessary to refer you to a specialist, the cost of which is your responsibility. (Initials_____)

Periodontal Loss (Tissue & Bone)

I understand that I have a serious condition, when left untreated may cause gum and bone inflammation and may lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and or extractions. I have also been made aware that I may need restorative treatment during periodontal therapy (i.e. fillings, root canals, cleanings, sedative fillings, temporary crowns, etc.). This form of stabilization is performed as a temporary measure, does not guarantee longevity of teeth and is independent of periodontal treatment. (Initials_____)

Cosmetic Dentistry

I acknowledge that I am choosing to change the appearance of my teeth by ways of alteration, supervised product use or by other means such as to enhance the physical appearance of my teeth. With some cosmetic procedures, I realize that I may experience pain, sensitivity, uneven coloring , discoloration which could lead to other procedures. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment and or crowns which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning. (Initials_____)

Specialist Referral

I understand that it may be necessary to be referred to a specialist due to conditions found during dental treatment as deemed necessary by the practitioner. (Initials_____)

General Dentistry Agreement and Acknowledgement

I understand that dentistry is not an exact science and that therefore practitioners cannot always guarantee results. I acknowledge that no guarantee or assurance has been made y anyone regarding the dental treatment, which I have requested and authorized. I understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.

By signing the bottom line of this page, you give the permission of the practitioner to perform general dentistry procedures with the knowledge that there can be no guarantee regarding the dental treatment performed.

_____ _____

Signature of Patient/Parent **Date**

_____ _____

Doctor **Date**