



WESTMOUNT DENTAL

Family & Cosmetic Dentistry

Thank you for visiting Westmount Dental. Please complete **both sides** of this form.

Confidential Patient Information

Date: ___ / ___ / ___
D M Y

Patient Name: _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Phone (Cell): _____ Phone (Home): _____ Phone (Work): _____ ext. _____

Address: _____
STREET APARTMENT NO. CITY PROVINCE POSTAL CODE

Birth Date: ___ / ___ / ___ Emergency Contact: _____ Phone: _____
D M Y

Health Information

Last Dental Visit: _____ Reason for This Visit: Pain Sensitivity Hygiene Cosmetics Other _____

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

CONDITIONS

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> HIV and/or AIDS | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Heart Attack (Yr _____) | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Stroke (Yr _____) |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Surgically Constructed Shunts |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bacterial Endocarditis | <input type="checkbox"/> Value: ___ / ___ | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problems | |
| <input type="checkbox"/> Crohn's or Colitis | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Mitral Valve Prolapse & Significant Regurgitation | |
| <input type="checkbox"/> o Repaired (Yr _____) | <input type="checkbox"/> Oral Herpes (Cold Sores) | |
| <input type="checkbox"/> o Unrepaired | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Cyanotic Heart Disease | <input type="checkbox"/> Pace Maker | |
| <input type="checkbox"/> Diabetes, Sugar Level _____ | <input type="checkbox"/> Psychiatric Problems | |
| <input type="checkbox"/> Epilepsy or seizures | | |

IF FEMALE

- Y N
- Taking Birth Control?
- Currently pregnant?
If yes, no. of weeks _____
- Currently nursing?

ALLERGIES

- Codeine
- Erythromycin
- Latex
- Penicillin
- Other _____

MEDICATIONS:

Whom may we thank for referring you to our practice?

- Shopping in plaza Road sign Another patient: _____
- Mail Advertisement On-line / website Child's Health Program (School: _____)

E-mail address (for confirmation of appointments): _____

Why did you leave your previous dentist? _____

What did you like **most** about your previous dentist? _____

What did you like **least** about your previous dentist? _____

Insurance Holder's Information

Primary Insurance Plan

Name of Insured: _____
LAST FIRST MI

Insured Birth Date: ___/___/___ ID Number: _____ Group Number: _____
D M Y

Insured's Address if different: _____
STREET APT NO. CITY PROVINCE POSTAL CODE

Insured's Employer's Name: _____

Patient's Relationship to insured: Self Spouse Child Other _____ Male Female

Insurance Plan Name: _____

Secondary Insurance Plan

Name of Insured: _____
LAST FIRST MI

Insured Birth Date: ___/___/___ ID Number: _____ Group Number: _____
D M Y

Insured's Address if different: _____
STREET APT NO. CITY PROVINCE POSTAL CODE

Insured's Employer's Name: _____

Patient's Relationship to insured: Self Spouse Child Other _____ Male Female

Insurance Plan Name: _____

Please INITIAL all applicable items:

_____ I authorize release from my insurance company plan administrator and CDA the information contained in insurance claims submitted electronically or by mail at Westmount Dental.

_____ I hereby assign my benefits payable from insurance claims submitted electronically or by mail to Dr. M. Buzaglo and Associates at Westmount Dental and authorize payment directly to him/her.

_____ 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 and staff at Westmount Dental at my next appointment without fail.

Financial Policies

- ◇ The benefits you receive from your insurance company are between you, your employer and your insurance carrier. **Any benefit difference is your responsibility, which includes deductibles, fee guide differences, ineligible services or copayments.**
- ◇ **Payment for services rendered is due on the day of treatment**, unless otherwise specified in a written financial arrangement or if Westmount Dental has been assigned benefits directly from your insurance carrier.
- ◇ A service charge of 1½% per month (18% per year) on the unpaid balance will be charged on all accounts **exceeding 90 days**, unless previously written financial arrangements are satisfied.

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

Signature of patient, parent, guardian or guarantor of payments

Date

Relationship to patient

Printed name of patient, parent, guardian or guarantor of payments