Mark A. Westhoff, D.D.S.
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Welcome

626 W. Centennial
Carthage, MO 64836
417-358-9006

We are pleased to welcome you to our practice. We look forward to working with you in maintaining your dental health. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Personal Information

Name _____ SS# _____

Address _____

City/State/Zip _____ Phone _____

Sex ☐ M ☐ F Age _____ Birth Date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____

Home Phone _____ Work Phone _____

Primary Insurance

Person Responsible for Account _____

Relation to Patient _____ Birth Date _____ SS# _____

Address (if different from patient) _____ Home Phone _____

City/State/Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contract# _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Dental History

Why did you come to see us today? _____ Are you in dental discomfort today? _____

Former Dentist _____

Address _____ Phone _____

Date of last dental care _____ Date of last X-rays _____

Check (✓) if you have had problems with any of the following:

☐ Bad breath	☐ Food collection between teeth	☐ Periodontal Treatment	☐ Sensitivity to sweets
☐ Bleeding gums	☐ Grinding or clenching teeth	☐ Sensitivity to cold	☐ Sensitivity when biting
☐ Clicking or popping jaw	☐ Loose teeth or broken fillings	☐ Sensitivity to hot	☐ Sores or growths in mouth

How often do you brush? _____ Floss? _____ How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Other information about your dental health or previous treatment _____

Medical History

Physician's Name _____ Phone _____

Date of last visit _____ Have you had any serious illness or operations? ☐ Yes ☐ No

If yes, then describe _____

Are you currently under physician care? ☐ Yes ☐ No If yes, then describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? ☐ Yes ☐ No

WOMEN: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills ☐ Yes ☐ No

Check (✓) if you have had any of the following:

- ☐ AIDS/HIV Positive
- ☐ Anaphylactic Shock
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough Up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food Allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe _____
- ☐ Hemophilia/ Abnormal Bleeding
- ☐ Herpes
- ☐ Hepatitis ABC
- ☐ High Blood Pressure
- ☐ Jaw Pain
- ☐ Kidney Disease or Malfunction
- ☐ Liver Disease
- ☐ Material Allergies (Latex, Wool, Metal, Chemicals)
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker/Heart Surgery
- ☐ Psychiatric Care
- ☐ Rapid Weight Gain or Loss
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic/Scarlet Fever
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Surgical Implant
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Disease or Malfunction
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Ulcer/Colitis
- ☐ Venereal Disease

List medications you are currently taking, if any:

_____

_____

_____

_____

LIST DRUG ALLERGIES, IF ANY

_____

_____

_____

_____

Authorization and Financial Agreement

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to m for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. 18% interest will be added to past due accounts.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.