Westmere
DENTAL CARE
SMILE WELL. BE WELL.

Welcome to Our Practice

On behalf of our entire team at Westmere Dental Care, we would like to welcome you to our practice. We are grateful that you have chosen us for your dental needs and trust you will find your experience in our office to be warm, friendly and professional.

You may discover that we are different from the average dental practice. When visiting our office, you will find a comforting and relaxing environment. Our team is compassionate and attentive; ready to answer any questions or concerns you may have. We use the latest technology and techniques that our profession has to offer.

In order to serve you better, we have enclosed several important forms that will assist us in making your transition to our practice as smooth as possible. We ask that you read and complete all forms two weeks prior to your visit. Please return the completed forms via email WestmereDentalCare@mydentalmail.com or use the enclosed self-addressed stamped envelope. Your first visit will last approximately 90 minutes. Please bring your photo id on your first visit. If you also bring your insurance id card we would be happy to file your insurance claim so you can receive any out of network reimbursement from your insurance.

Your overall health and wellness is important to us. Please call us at 518-218-0713 anytime should you have questions or concerns. We are looking forward to meeting you and taking care of your dental needs.

Sincerely,

The Westmere Dental Care Team

PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST FIRST MI	DATE OF BIRTH	SEX / GENDER IDENTITY	SSN(US) / SIN(CAN)

PREFER TO BE CALLED	HOME PHONE #	CELL PHONE #

PATIENT'S ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE	E-MAIL

MARITAL STATUS S M W D UNDER AGE 18	PATIENT'S / GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE	WORK PHONE #

SPOUSE'S NAME LAST FIRST MI	SPOUSE'S EMPLOYER	OCCUPATION

SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE	WORK PHONE #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP

HOME PHONE #	WORK PHONE #	CELL PHONE #

REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

	YES	NO
Contact me at home		
Contact me via cell phone		
Contact me at work		
Contact me via e-mail		
Leave messages on my home voicemail		
Leave messages on my cell phone voicemail		
Leave messages on my work voicemail		

PLEASE PRINT

Insurance And Financial Information

INSURANCE COVERAGE YES NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS GENDER IDENTITY	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CAN)
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

SECONDARY COVERAGE YES NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CA)
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

Release Information

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers			1.
Insurance Companies			2.

Confirmations

DO YOU PREFER A CONFIRMATION CALL

No, it is unnecessary Yes, it is a helpful reminder

Assignment & Release

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE

If the above named Patient is a minor or unable to pay the his/her Uninsured Costs, the undersigned agrees to guaranty the payment of such Uninsured Costs to the Patient's dentist in accordance with his/her payment terms and policies.

SIGNATURE - GUARANTOR OF PATIENT	DATE

Dental History

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ___/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐

GUM AND BONE	YES	NO
7. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐

TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT	YES	NO
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS	YES	NO
33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	☐	☐
34. Have you ever whitened (bleached) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex _____		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (e.g., sleep apnea, snoring, sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐
26. osteoporosis/osteopenia (e.g., taking bisphosphonates) _____	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

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DISCLOSURE FORM

Westmere Dental Care ("Practice") may disclose Protected Health Information ("PHI") about you to your family, close personal friends or any person that you identify, as long as the information disclosed to those individuals is relevant to their involvement in your care or the payment for your care. Practice also may notify a family member or another person who is responsible for your care of your location and general health condition. This form provides you with the opportunity to elect whether or not you wish to have your health information disclosed to individuals involved in your care.

Please initial one of the following to indicate your choice regarding such disclosures:

_____ I ***do not object*** to my PHI being disclosed to a family member, friend, or another individual involved in my care. The following is a list of those individuals to whom you may disclose my PHI:

Name	Relationship

_____ I ***object*** to my PHI being disclosed to a family member, friend or another individual involved in my care.

_____
Patient name (please print)

_____ _____
Signature of patient or patient representative Date

_____ _____
Relationship of patient representative to the patient Date

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Financial Policy

Thank you for choosing Westmere Dental Care. We are committed to providing you with the highest quality dental care using the best material and technology available today. We are also committed to providing you with up-to-date information and educational tools so that you can fully participate in maintaining optimum oral health and well-being. An important part of the mission is making the cost of your dental care manageable by offering several payment options.

Payment Options

You can choose from

- Cash, Check, Visa, Mastercard, American Express and Discover
- We also offer payment plans through Care Credit

Please Note:

All charges that you incur are your responsibility regardless of insurance coverage and are due at time of service. *We must emphasize that as your dental care provider, our relationship is with you, not your insurance company. Your insurance policy is a contract between you, your employer and the insurance company.* We can only estimate what an insurance company's out of network benefits will be for your service.

If you have any questions, please do not hesitate to ask. We are here to help you get the best dentistry that you want and need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please print)

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AUTHORIZATION TO RELEASE/REQUEST TO ACCESS MEDICAL, DENTAL, OR BILLING RECORDS

Patient Full Name: _____ Date of Birth: _____
Address: _____ Phone: _____
Requesting Patient Representative (if Different from Patient): _____
Purpose of Release: _____Self _____Other _____

____ I Authorize For My Records to Be Released to:

Practice, Dentist, Or Individual's Name: _____
(If requesting a copy for yourself, please enter "self")
Address: _____
Phone Number: _____ Fax Number: _____
E-Mail Address: _____

____ I Authorize for My Records to Be Obtained From:
Previous Practice or Dentist Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Email Address: _____

Please Specify the Records Being Requested:

_____Office & Treatment Notes _____ X-Rays & Images _____ Billing _____ All Records

I Understand that This Authorization is Voluntary and that Information to be Released/Obtained May Include, Medical, Psychiatric, Substance Abuse and/or HIV/AIDS Treatment Information, Until Otherwise Specified:

Limitations/Restrictions for Release: _____

Please Specify the Date Range of Records Being Requested: _____ To _____ _____All Past And Present Records
The Records Should Be: _____Mailed USPS _____Encrypted Email _____Faxed Other_____
This Authorization Expires (Date or Event): _____

_____ _____
Patient/Representative Signature Relationship to Patient (if Representative)

Today's Date: _____

You or your representative has the right to revoke this Authorization at any time by submitting a written request. Your revocation will not affect any uses or disclosures permitted by your Authorization while it was in effect. Please see the requirement for written authorization section in our Notice of Privacy Practices.

Generally, the provider may not condition its healthcare on the provision of the authorization except: (i) for research-related treatment or (ii) if the purpose of the healthcare is to create information for disclosure (such as an employment physical) in which case, the provider may refuse to provide the healthcare if you or your representative refuse to execute an authorization. The information disclosed per this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.