CHRISTOPHER R. WESTFALL D.M.D.

2301 Evesham Road Suite 205, Voorhees, NJ 08043

I. PATIENT INFORMATION

Circle one
Mr. Mrs. Ms.Miss
Other_____

Date_____

Last Name:_____First Name:_____

Middle Initial _____Nickname:_____

Check Appropriate box ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorcecd ☐ Widowed

Home Address_____City_____State_____Zip_____

Home Phone_____Work phone_____

Cell Phone:_____ E-mail address_____

Date of Birth _____/_____/_____ Age:_____ Drivers License: Office will copy

Employed By:_____ SS#_____-_____-_____ College/ if student _____

Name of Spouse/Guardian:_____ Patient's Occupation:_____

Whom may we thank for referring you to our office _____

In case of emergency who should be notified?**(outside of your home)**_____

Phone_____

II. MEDICAL HISTORY

Physician' s name: _____Phone number:_____Date of last physical_____

Please check : Yes /NO

Heart Problems	Y/N	Blood Disease	Y/N	Epilepsy	Y/N
High Blood Pressure	Y/N	Headaches	Y/N	Swollen Neck Glands	Y/N
Low Blood Pressure	Y/N	Hepatitis ,Jaundice	Y/N	Kidney disorder	Y/N
Circulatory Problems	Y/N	Liver Disease	Y/N	Special Diet	Y/N
Heart Murmur	Y/N	Cancer	Y/N	AIDS or Immunosuppressive Disorders	Y/N
Mitral Valve Pro Lapse	Y/N	Radiation Treatment	Y/N	HIV Positive	Y/N
Artificial Heart Valves or Joints	Y/N	Chronic Diarrhea	Y/N	Nervous Problems	Y/N
Recent Weight Loss	Y/N	Allergies to Anesthetics	Y/N	Psychiatric Care	Y/N
Diabetes	Y/N	Allergies to Latex Products	Y/N	Ulcer	Y/N
Asthma/Respiratory Disease	Y/N	General Allergies	Y/N	Venereal Disease	Y/N
Stroke	Y/N	Allergies to Medicine/Drugs	Y/N	Chemical Dependency	Y/N
Arthritis	Y/N	_____		Pregnant or Nursing	Y/N
Back problems	Y/N	Pacemaker	Y/N	Sinus Problems	Y/N
Hemophilia	Y/N	Allergies to any metals	Y/N	Prior Phen-phen use	Y/N
Rheumatic Fever	Y/N	Tuberculosis	Y/N	Other	_____

Are you under the care of a physician? Yes ☐ No ☐ If yes, for what?_____

_____

Are you taking medication at this time? Please list _____

_____

Do you need to be premedicated for dental treatment? Yes ☐ No ☐ If yes, why?_____

Do you smoke ? Yes ☐ No ☐ How much_____History of alcohol/drug use Y / N

Have you ever responded adversely to medical or dental treatment?_____

Have you taken any type of Bisphosphonate drug in the past 10 years? These include:

Zometa ☐ Aredia ☐ Boniva ☐ Actone ☐ Fosamax ☐

Is there anything else we should know about your medical history?_____

III. New Patients Only

Name of your previous Dentist _____Date of last dental visit_____

Reason for your visit _____

If you could change something about your smile , what would it be? _____

_____

********** **OVER**

For Office Use Only **Changes/Remarks**

1. _____ _____ Date_____

2. _____ _____ Date_____

3._____ _____ Date_____

III. PRIMARY DENTAL INSURANCE COVERAGE

POLICY HOLDERS NAME_____ ID#_____
ADDRESS (IF DIFFERENT)_____
Relation to Patient:_____SS#_____-_____-_____Date of Birth:_____
Employer Name and Address_____
_____
Plan Name (if different)_____
Group Number:_____Family Yr. Deductible :_____ Individual Yr. Deductible_____
Renewal date of plan_____Is this a Cobra Account?_____

IV. SECONDARY DENTAL INSURANCE COVERAGE (IF APPLICABLE)

POLICY HOLDERS NAME_____ ID#_____
ADDRESS (IF DIFFERENT)_____
Relation to Patient:_____SS#_____-_____-_____Date of Birth:_____
Employer Name and Address_____
_____
Plan Name (if different)_____
Group Number:_____Family Yr. Deductible :_____ Individual Yr. Deductible_____
Renewal date of plan_____Is this a Cobra Account?_____

V. RESPONSIBLE PARTY

Person Responsible for Account:_____Relationship:_____Date of Birth_____
Address:_____
Home phone:_____Work Number:_____Ext. _____
Employer:_____Occupation:_____
SS#_____-_____-_____

"Patient Responsibility"- There is NO GUARANTEE of payment by your insurance company, due to coinsurances and deductibles.
I am aware that I am financially responsible for any charges pertaining to my dental care or that of my child, if a minor. I authorize the use of my signature on file to be used as valid as the original. This would pertain to insurances purposes only. A $5.00 per month rebilling fee will be added to all accounts carried over 60 days, and accounts over 90 days may be forwarded to a collection agency. Charges will be applied for broken or cancelled appointments without 24 hours notice.

I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____
Date_____