

## Patient Information

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Zip: \_\_\_\_\_ Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Sex: M F  
 E-Mail Address: \_\_\_\_\_ DL/ID #: \_\_\_\_\_ State: \_\_\_\_\_ Type: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Position: \_\_\_\_\_ How Long: \_\_\_\_\_ years \_\_\_\_\_ months  
 Employer Address: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_ Ext.: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Medical Insurance Carrier \_\_\_\_\_ Are you / have you had a contract with Western Dental?  Yes  No  
 Spouse First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Cell: \_\_\_\_\_

## Responsible Party (Disregard if same as above)

Relationship to Patient: \_\_\_\_\_  
 First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Zip: \_\_\_\_\_ Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Sex: M F  
 E-Mail Address: \_\_\_\_\_ DL/ID #: \_\_\_\_\_ State: \_\_\_\_\_ Type: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Position: \_\_\_\_\_ How Long: \_\_\_\_\_ years \_\_\_\_\_ months  
 Employer Address: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_ Ext.: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Medical Insurance Carrier \_\_\_\_\_

## Emergency Contacts

**Contact # 1** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 How many years have you known this person? \_\_\_\_\_  
**Contact # 2** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 How many years have you known this person: \_\_\_\_\_  
**Contact # 3** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 How many years have you known this person: \_\_\_\_\_

## Primary Insurance Information

Insured First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Patient's relationship to Insured (Circle) Self Spouse Child Parent Sex: M F Insured's Social Security Number \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employer's Phone Number: \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Phone Number of Insurance Co. \_\_\_\_\_  
 Insurance Co. Address \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Name of Union and Local Union Number \_\_\_\_\_

## Secondary Insurance Information

Insured First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Patient's relationship to Insured (Circle) Self Spouse Child Parent Sex: M F Insured's Social Security Number \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employer's Phone Number: \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Phone Number of Insurance Co. \_\_\_\_\_  
 Insurance Co. Address \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Name of Union and Local Union Number \_\_\_\_\_

### Financial Responsibility

I request that all dental benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of service. I understand that I am financially responsible for all charges for services performed by provider. If insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors' assistants and other medical personnel. Failure to provide complete information may result in my receiving a bill for services.

### Verification and Collections

I certify that all information is complete and correct. Western Dental may verify this information from whichever sources it deems necessary (including, but not limited to, credit reports) and may provide others with information regarding my credit history (or the credit report), contact information, and social security number to the extent permitted by law. This is my authorization for Western Dental to verify identity and credit history. By providing Western Dental with my cell phone number, I consent to receiving autodialed and prerecorded message calls from Western Dental or its third party debt collector at that number and at any cell phone numbers I provide in the future.

### Consent to Record, Video and Audio

I authorize Western Dental and its employees, agents, and representatives to film and record today's patient visit and treatment, and all future patient visits and treatment for use by Western Dental for its health care operations, including, but not limited to: quality assessment and improvement activities, including case management and care coordination; competency assurance activities; conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; business planning, development, management, and administration; and business management and general administrative activities.

Signature of Patient: \_\_\_\_\_ Signature of Responsible Party: \_\_\_\_\_

## For Office Use Only

Date: \_\_\_\_\_ Other WDS contracts: \_\_\_\_\_ Signature of Employee: \_\_\_\_\_



# HEALTH HISTORY

Date (MM/DD/YYYY)

Chart Number

Instructions: Answer all of the questions on this form. Examples of markings:

Good Samples



Bad Samples



Patient First Name

MI

Last Name

Age

Height (feet - inches)

Weight (lbs)

Primary Phone #

Gender

Male

Female

In case of any emergency, contact (person)

Why are you here today?

When was your last visit to a dental office?

When were your last dental x-rays taken?

Are those x-rays available?

Yes

No

Prior Dentist Name

Prior Dentist Phone #

- Are you in good health?  Yes  No
- Have you had any serious illness, an operation, or hospitalization in the last 5 years? (Describe on page 3)  Yes  No
- Have there been any changes in your general health within the past year?  Yes  No
- Are you currently under the care of a physician? (Describe on page 3)  Yes  No

- Ankles swell  Yes  No
- Shortness of breath when you lie down, or you require extra pillows when you sleep  Yes  No
- A cardiac pacemaker  Yes  No
- Low blood pressure  Yes  No
- Sinus trouble  Yes  No
- Asthma  Yes  No

Do you have or have you had any of the following diseases or conditions?

- Damaged heart valves or artificial heart valves  Yes  No
- Congenital heart lesions or murmurs  Yes  No
- High blood pressure  Yes  No
- Heart attack  Yes  No
- Coronary insufficiency  Yes  No
- Coronary occlusion  Yes  No
- Arteriosclerosis  Yes  No
- Stroke  Yes  No
- Coronary bypass  Yes  No
- Coronary artery shunt  Yes  No
- Other cardiovascular disease/condition  Yes  No
- Pain in your chest upon exertion  Yes  No
- Shortness of breath after mild exercise  Yes  No

- Emphysema or respiratory problems  Yes  No
- Tuberculosis  Yes  No
- Persistent cough or cough up blood  Yes  No
- Fainting spells or seizures  Yes  No
- Diabetes  Yes  No
- Urination (pass water) more than 6 times a day  Yes  No
- Thirsty much of the time  Yes  No
- Mouth frequently becomes dry  Yes  No
- Kidney trouble  Yes  No
- Stomach troubles/ulcers  Yes  No
- Hepatitis, jaundice or liver disease  Yes  No
- Sexually transmitted disease  Yes  No
- HIV/AIDS  Yes  No
- Herpes  Yes  No

Current Physician's Name

Current Physician's Phone #

Address

Suite#

City

State

Zip Code



# HEALTH HISTORY

38. Arthritis or painful, swollen joints  Yes  No

39. Lupus /Autoimmune disease  Yes  No

40. Prosthetics (Check all that apply)

- A. NONE
- B. Prosthetic hip
- C. Implant
- D. Bone Screw
- E. Joint prosthesis
- F. Bone plate
- G. Other (Describe on page 3)

41. Blood disorder such as anemia  Yes  No

42. Abnormal bleeding associated with previous surgery, trauma or dental extractions  Yes  No

43. Bruise easily  Yes  No

44. Have you ever required a blood transfusion? (Describe on page 3)  Yes  No

Do you use or have you used any of the following:

45. Tobacco: smoking

- A. No
- B. Less than one pack a day
- C. One pack a day
- D. More than one pack a day

46. Tobacco: chewing

- A. No
- B. Less than once a day
- C. Once a day
- D. More than once a day

47. Alcohol

- A. No
- B. Less than one drink a day
- C. One drink a day
- D. More than one drink a day

48. Recreational drugs  Yes  No

49. Have you taken the diet medication Redux (Fen-Phen)?  Yes  No

50. Are you taking any medications? (Check all that apply)

- A. Antibiotics or sulfa drugs
- B. Medicine for high blood pressure
- C. Antidepressants
- D. Antihistamines
- E. Insulin, tolbutamide (orinase) or similar
- F. Nitroglycerin
- G. Medicine for osteoporosis: Fosamax, Aredia, Boniva, Zometa (Bisphosphonates)
- H. Anticoagulants (blood thinners)
- I. Cortisone / Prednisone (steroids)
- J. Sedatives
- K. Aspirin
- L. Digitalis or drugs for heart trouble
- M. Oral contraceptives or other hormonal therapy
- N. Herbal remedies (Describe below)
- O. Any other drug or medicine? (Describe on page 3)
- P. NONE

51. Are you allergic or have you reacted adversely to any of the following? (Check all that apply)

- A. Local anesthetics
- B. Medicine for high blood pressure
- C. Sulfa drugs
- D. Aspirin
- E. Codeine or other narcotics
- F. Latex
- G. Penicillin or other antibiotics
- H. Cortisone / Prednisone (steroids)
- I. Barbiturates, sedatives or sleeping pills
- J. Iodine
- K. Nickel or other metals
- L. Other allergies (Describe on page 3)
- M. NONE

52. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or head?  Yes  No

53. Have you had chemotherapy treatment for cancer or any other disease? (Describe on page 3)  Yes  No

54. Are you employed in any situation that exposes you regularly to x-rays or other ionizing radiation?  Yes  No

55. Are you wearing contact lenses?  Yes  No

56. Do you have any problems associated with your menstrual period?  Yes  No

57. Are you pregnant?  Yes  No

58. Are you nursing?  Yes  No

59. Do any of your teeth hurt? (Describe on page 3)  Yes  No

60. How often do you brush your teeth? (Check one)

- A. Less than once a day
- B. Once a day
- C. More than once a day

61. When do you brush your teeth? (Check all that apply)

- A. Morning
- B. Evening
- C. After meals

62. How often do you floss? (Check one)

- A. Never
- B. Occasionally
- C. Once a day

63. Do your gums bleed or hurt?  Yes  No

64. Are any of your teeth sensitive to? (Check all that apply)

- A. Hot
- B. Sweets
- C. Cold
- D. Pressure
- E. NONE



# HEALTH HISTORY

65. Does food get caught in your teeth?  Yes  No

66. Do you have? (Check all that apply)

- A. Frequent headaches
- B. Neck aches
- C. Shoulder aches
- D. NONE

67. Do you clench or grind your teeth?  Yes  No

68. Have you experienced any pain or soreness in the muscles of your face or around your ear?  Yes  No

69. Does your jaw click or pop?  Yes  No

70. Is there anything about your teeth or smile that you would like to change? (Describe below)  Yes  No

71. Do you wear a partial denture, full denture or any other removable dental appliance?  Yes  No

72. Is there anything about your partial denture, full denture or any other removable dental appliance that you would like to change? (Describe below)  Yes  No

### Additional comments & descriptions

What was the illness, operation or hospitalization in the last 5 years from question 2?

What is the condition for which you are currently under the care of a physician from question 4?

What other implants or prostheses do you have from question 40?

What were the circumstances of your blood transfusion from question 44?

What other drugs or medicine do you take from question 50?

To what other drugs/materials are you allergic to or have you reacted adversely from question 51?

For what cancer or other disease have you had chemotherapy from question 53?

Which of your teeth hurt from question 59?

Is there anything about your teeth or smile that you would like to change from question 70?

Is there anything about your partial denture, full denture or any other removable dental appliance that you would like to change from question 72?

I hereby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the unsigned, consent to the performing of x-rays and examination.

Signature of PATIENT or GUARDIAN \_\_\_\_\_  
if patient is a minor

Date / /

Signature of DENTIST \_\_\_\_\_ ID#

Date / /

### UPDATE

Have there been any changes in your medical history, including any medications that you take, since you last completed this form?  Yes  No

Signature of PATIENT or GUARDIAN \_\_\_\_\_  
if patient is a minor

Dr. Signature \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_



# ARBITRATION AGREEMENT

## WAIVER OF RIGHT TO JURY TRIAL

Patient Chart No. \_\_\_\_\_

Patient Name: \_\_\_\_\_

Office Location: \_\_\_\_\_

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Arizona law, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review of arbitration proceedings. **Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.**

**Article 2: All Claims Must Be Arbitrated:** It is the intention and agreement of the parties that this arbitration agreement shall cover **all claims or controversies** relating to the matters described in Article 1 above, except claims within the exclusive jurisdiction of the Arizona Justice Courts, whether in tort (intentional or negligent), contract, or otherwise, including but not limited to suits relating to the matters described in Article 1 and also involving claims for loss of consortium, wrongful death, discrimination, emotional distress or punitive damages. Arbitration pursuant to the terms of this Contract shall bind all parties whose claims as described in Article 1 may arise out of or in any way relate to treatment or services provided or not provided by Western Dental of Arizona, Inc. ("Western") or any employee or agent or providers of Western, including any spouse or heirs of Patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. The undersigned understands and agrees that if the undersigned signs this Contract on behalf of some other person for whom the undersigned has responsibility, then, in addition to the undersigned, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person.

The reference to Western includes the corporation, and its employees, agents and providers. Filing any action in any court by Western to collect any fee from Patient shall not waive the right to compel arbitration of any claim described in Article 1. However, following the assertion of any claim against Western, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by the same arbitration.

**Article 3: Procedures and Applicable Law:** Patient shall initiate arbitration by serving a Demand for Arbitration on Western and each defendant. The claim shall be mailed by U.S. mail, postage prepaid, to: General Counsel, Western Dental, 530 S. Main Street, Suite 600, Orange, CA 92868. A Demand for Arbitration must be communicated in writing to all parties, identify each defendant, describe the claim against each party, and the amount of damages sought, and the names, addresses and telephone numbers of the Patient and his/her attorney. Patient and Western agree that any arbitration hereunder shall be conducted by a single, neutral arbitrator selected by the parties and shall be resolved using the rules of the American Arbitration Association. (Arbitration, however, shall not be conducted by the American Arbitration Association.). Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Arizona Revised Statute §§ 12.1501 et. seq., Arizona law and procedures, and the Federal Arbitration Act (9 U.S.C. §§ 1- 9), as in effect from time to time.

**Article 4: Retroactive Effect:** Patient intends this Contract to cover services rendered by Western not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

**Article 5: Severability:** If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this Contract. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

\_\_\_\_\_  
Print Patient's Name (Signature of Patient, Parent, Guardian or Legally Authorized Representative of Patient) Dated: \_\_\_\_\_, 20 \_\_\_\_\_

### WESTERN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing agreements under this Contract, Western likewise agrees to be bound by the terms set forth in this Contract and to the rules specified in Article 3 above.

\_\_\_\_\_  
Prepared By Western Employee Print Name Date Signed

A signed copy of this document is to be given to Patient. The Original is to be filed in Patient's dental chart.



Dear Patient,

In keeping with the standards of the profession and the recent developments in sterilization and infection control, we at Western Dental have formulated this general public information bulletin to give our patients an idea of how seriously we take the safety and well being of our patients.

- 1) All doctors, hygienists and assistants wear gloves, masks, and face shields or goggles.
- 2) Doctors and assistants wash their hands and change gloves with every patient.
- 3) Dental drill handpieces are cleaned, bagged and sterilized prior to use on each patient.
- 4) All instruments are scrubbed, cleaned, bagged and sterilized according to guidelines set forth by the Center for Disease Control & Prevention.
- 5) All instruments are sterilized in autoclaves or chemical vapor sterilizers according to recommended procedures. If the instruments are heat sensitive, an overnight (10 + hours) sterilized soak is done.
- 6) Western Dental test all sterilizers weekly and this is confirmed through independent lab analysis.
- 7) All operating surfaces are cleaned with EPA registered hospital grade surface disinfectants.
- 8) Many disposable items are used. Once used, they are discarded. Some examples are the injection needles, plastic suction tips and the polishing cups.
- 9) An independent company has been retained to vaccinate and test our staff for the Hepatitis B virus.
- 10) Our staff, while taking x-rays, always use fresh gloves and each x-ray holder is individually bagged and sterilized.
- 11) Infection control seminars are held for all our dental offices throughout the year.
- 12) Our company has retained an infection control consultant who randomly inspects our offices on a routine basis. Many of these inspections are done on a "surprise" basis to ensure that the offices are following accepted guidelines. In addition to these inspections, our own administrative staff performs regularly scheduled audits on all our offices.

Western Dental provides dental care services without discrimination based on race, religion, color, national origin, sex, sexual orientation, physical or mental disability, age or marital status and protects the privacy of each of its patients. If any questions or concerns arise regarding the dental care, treatment or services you have received, contact Western Dental Of Arizona Inc. at 1-800-992-3366 or write the Western Dental Of Arizona, Inc., P.O. Box 14227, Orange, California, 92863.



## HOW DID YOU HEAR OF US ?

• PLEASE CHECK ONE BOX ONLY !

NAME \_\_\_\_\_

ZIP CODE \_\_\_\_\_

OFFICE \_\_\_\_\_

DATE \_\_\_\_\_

- A.  SPANISH T.V.
- B.  ENGLISH T.V.
- C.  SPANISH RADIO
- D.  ENGLISH RADIO
- E.  FLYER / MAILER / COUPON
- F.  NEWSPAPER / MAGAZINE
- G.  SPANISH YELLOW PAGES
- H.  ENGLISH YELLOW PAGES
- I.  BILLBOARD / BUS SIGN
- J.  BUILDING LOCATION SIGN

- K.  FRIEND / NEIGHBOR / RELATIVE
- L.  TELEPHONE / LETTER / RECALL
- M.  DENTAL PLAN REFERRAL
- N.  MANAGED CARE - (GMC, ETC.)
- O.  W.D. VAN 1-800-844-4444
- P.  W.D. BOOTH (SWAPMEET, SPECIAL EVENT, ETC.)
- Q.  INTERNET
- R.  **W.D. DENTIST**
- S.  **W.D. ORTHODONTIST**

Form 232 (Rev. 11/08)



## ¿CÓMO ENCONTRÓ INFORMACIÓN SOBRE NUESTRO CONSULTORIO?

¡POR FAVOR, MARQUE UN CUADRO SOLAMENTE!

NOMBRE \_\_\_\_\_

ZONA \_\_\_\_\_

OFICINA \_\_\_\_\_

FECHA \_\_\_\_\_

- A.  TELEVISIÓN EN ESPAÑOL
- B.  TELEVISIÓN EN INGLÉS
- C.  RADIO EN ESPAÑOL
- D.  RADIO EN INGLÉS
- E.  VOLANTES/AVISOS POR CORREO/CUPONES
- F.  PERIÓDICO/REVISTA
- G.  GUÍA TELEFÓNICA EN ESPAÑOL
- H.  GUÍA TELEFÓNICA EN INGLÉS
- I.  CARTELERA/ANUNCIO EN EL AUTOBÚS
- J.  CARTEL EN UN EDIFICIO

- K.  AMIGOS/VECINOS/PARIENTES
- L.  TELÉFONO/CARTA/RECORDATORIO
- M.  REFERENCIA POR PARTE DE UN PLAN DENTAL
- N.  ATENCIÓN COORDINADA (GMC, ETC.)
- O.  CAMIONETA DE WESTERN DENTAL 1-800-844-4444
- P.  QUIOSCO DE WESTERN DENTAL (FERIAS AL ESTILO "SWAPMEET", ALGÚN EVENTO ESPECIAL, ETC.)
- Q.  INTERNET
- R.  **UN DENTISTA DE WESTERN DENTAL**
- S.  **UN ORTODONCISTA DE WESTERN DENTAL**