WESTLAKE
SMILE DESIGN

Welcome to Westlake Smile Design

PATIENT INFORMATION

Date__________ Home Phone (_____)__________ Cell Phone (_____)__________ Work (_____)__________

Name __________ Social Security #__________

Address__________ E-mail__________

City__________ State__________ Zip__________

Sex ☐M ☐F Age__________ Birthdate__________ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Patient Employer/School__________ Occupation__________

Employer/School Address__________ Employer/School Phone (_____)__________

In case of emergency who should be notified__________ Relationship__________ Phone (_____)__________

How did you find out about our office?

☐ Personal referral from:__________ ☐ Postcards ☐ Internet (please list below) ☐ Other (please list below)

If you found us on the internet, what site did you find us on (eg. Yelp, office website etc…)? __________

If you checked "other", what was the source of referral? __________

PRIMARY INSURANCE

Person responsible for account__________

Relation to patient__________ Birthdate__________ ID#/Soc. Sec. #__________

Address (if different from patient's)__________ Phone (_____)__________

City__________ State__________ Zip__________

Person responsible employed By__________ Occupation__________

Business Address__________ Business Phone (_____)__________

Insurance Company__________

Contact #__________ Group #__________ Subscriber #__________

Names of other dependants covered under this plan__________

I certify that I, and/or my dependant(s), have insurance coverage with the above listed insurance company and assign directly to Dr. David Hakimi and Dr. Armon Eben all insurance benefits. I understand that I am financially responsible for all charges whether or not paid for by insurance. I authorize the use of my signature and any of my other information on all insurance submissions. I understand that payment is due in full at the time of the treatment.

Print name __________ Signature __________ Relationship to Patient __________ Date __________

DENTAL HISTORY

Reason for today's visit__________ Date of last dental care__________

Reason for leaving former dentist__________ Date of last dental x-rays__________

Please mark "yes" or "no" for the following:

Dry mouth	☐ yes ☐ no	Grinding teeth	☐ yes ☐ no	Sensitivity to hot	☐ yes ☐ no
Snoring	☐ yes ☐ no	Clenching teeth	☐ yes ☐ no	Sensitivity to cold	☐ yes ☐ no
Sleep apnea	☐ yes ☐ no	Clicking or popping jaw	☐ yes ☐ no	Sensitivity to sweets	☐ yes ☐ no
Past periodontal problems	☐ yes ☐ no	Jaw pain or tiredness	☐ yes ☐ no	Sensitivity when biting	☐ yes ☐ no
Do you snore	☐ yes ☐ no	Broken fillings or crowns	☐ yes ☐ no	Past need for root canal	☐ yes ☐ no
Have trouble sleeping	☐ yes ☐ no	Mercury "silver" fillings	☐ yes ☐ no	Past orthodontic treatment	☐ yes ☐ no
Daytime sleepiness/fatigue	☐ yes ☐ no	Food collection between teeth	☐ yes ☐ no	Sores/growths in your mouth	☐ yes ☐ no

How often do you floss?__________ How often do you brush?__________