



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

Separated Divorced Partnered for ____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified _____ Relationship _____ Phone (____) _____

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 _____ 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	<input type="checkbox"/> yes <input type="checkbox"/> no	Grinding teeth	<input type="checkbox"/> yes <input type="checkbox"/> no	Sensitivity to hot	<input type="checkbox"/> yes <input type="checkbox"/> no
Bad breath	<input type="checkbox"/> yes <input type="checkbox"/> no	Clenching teeth	<input type="checkbox"/> yes <input type="checkbox"/> no	Sensitivity to cold	<input type="checkbox"/> yes <input type="checkbox"/> no
Mouth breathing	<input type="checkbox"/> yes <input type="checkbox"/> no	Clicking or popping jaw	<input type="checkbox"/> yes <input type="checkbox"/> no	Sensitivity to sweets	<input type="checkbox"/> yes <input type="checkbox"/> no
Swollen or tender gums	<input type="checkbox"/> yes <input type="checkbox"/> no	Jaw pain or tiredness	<input type="checkbox"/> yes <input type="checkbox"/> no	Sensitivity when biting	<input type="checkbox"/> yes <input type="checkbox"/> no
Bleeding gums	<input type="checkbox"/> yes <input type="checkbox"/> no	Broken fillings	<input type="checkbox"/> yes <input type="checkbox"/> no	Past need for root canal	<input type="checkbox"/> yes <input type="checkbox"/> no
Loose teeth	<input type="checkbox"/> yes <input type="checkbox"/> no	Mercury "silver" fillings	<input type="checkbox"/> yes <input type="checkbox"/> no	Past orthodontic treatment	<input type="checkbox"/> yes <input type="checkbox"/> no
Past periodontal treatment	<input type="checkbox"/> yes <input type="checkbox"/> no	Food collection between teeth	<input type="checkbox"/> yes <input type="checkbox"/> no	Sores/growths in your mouth	<input type="checkbox"/> yes <input type="checkbox"/> no

How often do you floss? _____ How often do you brush? _____