Welcome

West Gate Dental

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

SS# _____
Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy. ☐ Discover

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin	☐	☐
Any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐
Acid Reflux	☐	☐	Osteoporosis	☐	☐			

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____ Signature _____ Date _____

West Gate Dental
Rebecca Sowers, DDS
251 Capitol Beach Blvd Ste #14
Lincoln, NE 68528
402-475-8710

NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE

You may refuse to sign this form and are entitled to a copy of this consent after you sign it.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations, including all instances listed on the notice of privacy practice that you have read before signing this consent.

Notice of Privacy Practices: Please read our notice of privacy practices before you decide whether to sign this consent. Our notice provides a description of your rights, your choices, and our responsibilities in protecting your privacy and healthcare information including a description of using this information to carry out treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice is posted in our office and is available upon request for your records. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our privacy practices, including any revisions of our notice, at any time by contacting: Rebecca Sowers, DDS, West Gate Dental, 251 Capitol Beach Blvd, Suite 14, Lincoln, NE 68528; 402-475-8710.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature: I have received a copy of this office's notice of privacy practices. I have had full opportunity to read and consider the contents of this consent form and your notice of privacy practices. I understand that by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations, including all instances listed on the notice of privacy practices.

Print Patient's Name:_____

Patient's Social Security Number:_____

Signature of Patient (or Parent):_____ Date:_____

Parents: If signing on behalf of a minor child, please print your name:_____

Personal Representative: If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

Refusal to Consent: Please sign here to acknowledge that you received a copy of our notice of privacy practices but refuse to consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations, including all instances listed in the notice of privacy practices.

Signature:_____

West Gate Dental
Rebecca Sowers, DDS
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Payment Policy

Payment is expected for services rendered on the day of service. We accept cash, check, Visa, MasterCard, and Discover for your convenience.

If you have dental insurance that we are able to verify, we will file your claims as a courtesy to you. However, you will be required to pay any deductibles, co-pays, and coinsurance percentages on the day of service. Any quotes given to you are estimates only and are subject to change.

In order to offer the courtesy of submitting insurance claims, you are responsible for providing us with accurate and current insurance information. Please notify us of ANY insurance company/coverage changes at the time you schedule your appointment or at the time of your visit.

Any unpaid balance on your account will be due in full within 15 days of receiving a statement. A finance charge of 1.50% per month (18% APR) will be charged on any balance more than 30 days past due.

For more extensive procedures, we do offer an interest free (must pay off balance in time allotted) payment plan through Care Credit. If you would like more information, please look them up at CareCredit.com or call 800-365-8295. Once you have applied and been given an account number you'd notify us and our office would do the rest. You would then receive monthly statements directly from Care Credit.

There is a $25.00 fee for all returned checks.

I am aware that the total given is an estimate only and is subject to change due to insurance coverage and or payments, treatment plan changes, or fee changes. This also includes any changes to your coverage or eligibility at the actual time of service. Pre-determination of benefits is not a guarantee of payment.

I have been informed of West Gate Dental's payment policy and I understand the contents. All questions and concerns have been addressed.

Signed:_____

Date:_____

West Gate Dental
Rebecca Sowers, DDS
251 Capitol Beach Blvd Ste #14
Lincoln, NE 68528
402-475-8710

In an effort to better maintain our schedule **WE REQUIRE A 24-HOUR NOTICE** for rescheduling appointments. This enables our office to give another patient the opportunity to be seen sooner. We understand that an occasional illness or activity occurs, however, our office policy states that a person and/or family will be dismissed if three (3) appointment s have been failed or rescheduled without 24-hour notice in a three year time period.
(example: mom and child are scheduled on the same day – this is two appointments for the family and no other appointments can be missed)

There is an exception for a new patient. If a new patient misses the initial appointment, no reappointment will be available.

I have read and understand this office policy. I have had an opportunity to have my questions answered.

Signed _____

Date _____

West Gate Dental
Rebecca Sowers, DDS
251 Capitol Beach Blvd Ste #14
Lincoln, NE 68528
402-475-8710

Email and Text Messaging Consent Form

We are happy to provide our patients with the option to participate in our email and texting communication system.

You may choose to discontinue your participation in our online communication system at any time. Please call the office for more information at 402-475-8710.

It is the patient's responsibility to update information as needed. Please provide us with the following contact information:

Home Phone:_____

Cell Phone:_____

Email:_____

We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction. We may disclose patient health information (PHI) to third parties that perform services for this practice in the administration of your benefits in accordance with HIPAA (Health Insurance Portability and Accountability Act of 1996). These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for this practice in the administration of your benefits. Our affiliates do not sell, share, or rent our users' personally identifiable information unless required by law, do not send any email or other communications without your permission, and do not send spam.

Please sign below to indicate you agree to allow us to use this information in providing these services.

_____

Signature Date