PATIENT INFORMATION:

Patient Name_____

Name you wish to be called_____ **Sex: Male ( ) Female ( )**

Address_____

City_____ **State**_____ **Zip**_____

Home Phone_____ **Cell Phone** _____ **Work Phone**_____ **Email** _____

Birthdate_____ **Social Security Number**_____

Employer_____**Occupation**_____

Spouse Name_____ **Spouse Social Security Number**_____

Spouse Employer_____**Occupation**_____

IN CASE OF AN EMERGENCY PLEASE CONTACT:

Name_____ Phone Number_____

Address_____

Physician's Name and Address_____

Who may we thank for referring you to our office?_____

INSURANCE INFORMATION:

Insurance Company: _____Group Number:_____
Subscriber Name:_____ Subscriber Birth date: _____
Subscriber Social Security Number_____ Relationship to Patient_____

I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance. I assign dental benefit payments to be paid directly to Allen Weiner, D.M.D., P.C. I authorize the use of this signature on all insurance submissions.

_____ _____
SIGNATURE DATE

Your answers to the following questions below are for our records only and will be considered confidential.

Do you now or have you ever had any of the following conditions?

	Yes	No		Yes	No
Heart Trouble			Bruise Easily		
Heart Murmur			Anemia		
Irregular Heart Beat			Excessive Bleeding		
Angina/Chest Pain			Sickle Cell Disease		
Congenital Heart Disorder			Leukemia		
Mitral Valve Prolapse			Recent Blood Transfusion		
Pacemaker/ Defibrillator			Lung Disease		
Rheumatic Fever			Asthma		
Heart Surgery			High Blood Pressure		
Tuberculosis now or in the past			Low Blood Pressure		
Persistent cough for more than 3 weeks			Cancer		
Cough that produces blood			Shortness of Breath		
Swelling of Limbs			Liver Disease		
Thyroid Disease			Diabetes		
Joint Replacement					
Blood Disease			Hepatitis A		
AIDS / HIV			Hepatitis B		
Allergic to or bad reaction to Latex, banana or kiwi?			Hepatitis C		
I am allergic to:			Bad reaction to local anesthesia? Describe:		

	YES	NO
Are you in good health?		
Has there been any change in you general health within the past year?		
Are you currently under the care of a physician?		
Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, please explain _____ _____		
Are you taking any medicine(s) including non-prescription medicine? If so, please list_____ _____		
Are you wearing contact lenses?		
Do you smoke? If so, how many packs per day?		
Do you use chewing tobacco? If so, how many cans per day?		
Do you drink alcoholic beverages? If so, how many drinks per day?		
Do you have frequent headaches, migraines, or any jaw discomfort? How frequently do you have headaches?_____ When do they occur?_____		

Women:

	YES	NO
Do you suspect or are you pregnant?		
Do you have any problems associated with your menstrual period?		
Are you nursing?		
Are you taking birth control pills?		

Clinical:

Previous Dentist_____
Previous Dentist Address_____
How long has it been since your last dental visit?_____
When were x-rays last taken of your teeth?_____
Reason for today's visit?_____

	YES	NO
Are you happy with the appearance of your teeth?		
Are you wearing any removable dental appliances?		
Do you have any specific concerns regarding your teeth? If yes please explain _____ _____		
Have you had serious trouble associated with previous dental treatment?		
Do you have a click, pop, or other noise in the jaw area? If yes, when do you hear the noise?_____		
Are your teeth sensitive to hot or cold?		
Are any teeth uncomfortable to bite on?		
Have you lost any teeth?		
Have you had any teeth replaced?		
Do you have any tooth or jaw discomfort?		
Do your gums bleed when brushing or flossing?		
Do you clench or grind your teeth?		
Do both your parents have their natural teeth?		
Is there anything about dentistry that you strongly dislike? Explain _____ _____		

I certify that I have read and understand the questions above. Any questions that I had in regard to these questions have been answered to my complete satisfaction. I will not hold Allen L. Weiner, DMD or any other member of his staff responsible for any errors or omissions that I may have made in completion of this form. I will advise Allen L. Weiner, DMD and his staff of any dental changes in my physical condition, health history, and /or changes in my medication. I understand that I may incur an 1.5% finance charge if my balance goes beyond 90 days. I give permission for Allen L. Weiner, DMD and his clinical team to take any necessary diagnostic films, photos, or study models to properly enable complete diagnosis.

_____ _____

PATIENT SIGNATURE (PARENT OR GUARDIAN) TODAY'S DATE