Welcome to the Dental Office of David J. Weiner, D.M.D., P.A.

DATE_____

Patient's Name:_____
Last First Middle

Address_____
City State Zip

Home phone:_____Date of birth _____ Social Security No._____

Driver's License No. _____ State_____ Expiration Date_____

Patient's (or parent/guardian) employer: _____Business Phone:_____

Business Address:_____
City State Zip

Cell Phone: _____ E-mail:_____ Alternate E-mail:_____
If applicable

Spouse's name: _____Employed by:_____ Business Phone_____

Business Address:_____
City State Zip

Person to contact in case of emergency:_____ Telephone(s)_____

How did you hear about our office?_____

DENTAL HEALTH INFORMATION

Reason for today's visit:_____

Date of last dental visit:_____ What was done then?_____

Do your gums bleed? Yes ☐ No☐ Do you floss your teeth? Yes ☐ No☐ How often?_____

Does your jaw ever click, pop, or cause you any discomfort? Yes ☐ No☐ Do you grind or clench your teeth? Yes ☐ No☐

Do you ever wake up with your jaw muscles tired, sore or do you have any discomfort whatsoever? Yes ☐ No☐

DO YOUR TEETH EVER HURT FROM:

Hot Yes ☐ No☐ Sweets Yes ☐ No☐ Brushing Yes ☐ No☐

Cold Yes ☐ No☐ Sour Yes ☐ No☐ Other_____

Chewing Yes ☐ No☐ Flossing Yes ☐ No☐ _____

PERSON RESPONSIBLE FOR THIS ACCOUNT (IF DIFFERENT FROM ABOVE)

Name_____ Relationship to patient:_____

Address: _____
City State Zip

Telephone_____ Relation to patient_____

PAYMENT IS REQUIRED WHEN SERVICES ARE RENDERED. WE ACCEPT CASH, CARE CREDIT PAYMENT PLAN, APPROVED CHECK, MASTERCARD, VISA, AMEX, DINERS CLUB AND DISCOVERY. THANK YOU.

(PLEASE CONTINUE ON REVERSE SIDE)

CONFIDENTIAL HEALTH HISTORY AND MEDICAL INFORMATION

1. Are you having pain or discomfort at this time? ..... Yes ☐ No ☐
2. Do you feel nervous about having dental treatment? ..... Yes ☐ No ☐
3. Have you ever had a bad experience in a dental office? ..... Yes ☐ No ☐
4. Have you been examined by or treated by a physician during the last two years? ..... Yes ☐ No ☐
   If yes, for what reason? _____
   Physician's Name_____ Telephone No._____
5. Have you ever been hospitalized? ..... Yes ☐ No ☐
   If yes, for what reason?_____
6. Have you ever had surgery of any type (other than cosmetic)? ..... Yes ☐ No ☐
   If yes, for what reason?_____
7. What are the dosage and medications that you take regularly? _____
8. Have you ever had unusual bleeding? ..... Yes ☐ No ☐
   If yes, please describe_____

   Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... Yes ☐ No ☐
   If yes, please describe_____
10. **THIS QUESTION FOR WOMEN ONLY:**
    Are you pregnant? Yes ☐ No ☐ If yes, what month?_____ Are you taking birth control pills? ..... Yes ☐ No ☐

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT. CIRCLE "YES" OR "NO" TO EACH ITEM

Heart Failure	YES	NO	Latex or Kiwi Fruit Allergy	YES	NO	Hepatitis A, B, or C	YES	NO
Heart Disease or Attack	YES	NO	Diabetes	YES	NO	Hepatitis Non A/ Non B	YES	NO
Angina Pectoris	YES	NO	Allergies or Hives	YES	NO	Liver Disease	YES	NO
High Blood Pressure	YES	NO	Emphysema	YES	NO	Yellow Jaundice	YES	NO
Chest Pain	YES	NO	Cough	YES	NO	Radiation Treatment	YES	NO
Heart Murmur	YES	NO	Tuberculosis (TB)	YES	NO	Drug Addiction	YES	NO
Mitral Valve Prolapse	YES	NO	Asthma	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve(s)	YES	NO	Hay Fever	YES	NO	Cold Sores or Fever Blisters	YES	NO
Heart Pacemaker	YES	NO	Sinus Problems	YES	NO	Leukemia	YES	NO
Rheumatic Fever	YES	NO	Epilepsy or Seizures	YES	NO	Nervousness	YES	NO
Congenital Heart Disease	YES	NO	Fainting or Dizzy Spells	YES	NO	Smoking	YES	NO
Scarlet Fever	YES	NO	Chemotherapy	YES	NO	Sickle Cell Disease	YES	NO
Thyroid Disease	YES	NO	Cancer	YES	NO	Bruise Easily	YES	NO
Artificial Joints	YES	NO	Arthritis	YES	NO	Herpes	YES	NO
Anemia	YES	NO	Rheumatism	YES	NO	TMJ	YES	NO
Stroke	YES	NO	Cortisone Medicine	YES	NO	Any Other Illnesses or Medical Conditions		
Ulcers	YES	NO	Glaucoma	YES	NO	Not Listed_____		
AIDS or HIV Positive	YES	NO	Kidney Problems	YES	NO			

11. When you walk up a flight of stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath or because you are tired? ..... Yes ☐ No ☐
12. Do your ankles swell during the day? ..... Yes ☐ No ☐
13. Do you use more than two pillows to sleep? ..... Yes ☐ No ☐
14. Have you gained or lost more than 10 pounds in the past year? ..... Yes ☐ No ☐
15. Do you ever wake up with shortness of breath? ..... Yes ☐ No ☐
16. Are you on a special diet? ..... Yes ☐ No ☐

IS THERE ANYTHING YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR OR DOCTOR'S ASSISTANT IN PRIVATE NOT INDICATED ABOVE? ..... Yes ☐ No ☐

APPOINTMENT CHANGE or CANCELLATION POLICY

X_____
Signature of Patient, Parent or Person Responsible

It is necessary for all patients to accept and adhere to our policy of <u>at least</u> 24 hours notice to change or cancel an appointment. Please initial to the right that you agree to this policy. X_____

I authorize the doctor and staff to perform an examination for the purpose of diagnosis and treatment planning. I authorize the taking of all x-rays, photographs and/or other records as required as a part of this examination. If necessary for medical or insurance purposes, I authorize release of information acquired in the course of my treatment.

I understand that the responsibility for payment for dental services provided in the office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% monthly finance charge (18% annually) will be added to any balance over 30 days. In the event of default, I (we) are responsible to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney's fees as may be required to effect collection of the note. I HAVE READ THE ABOVE STATEMENT AND THAT I FULLY UNDERSTAND THIS QUESTIONAIRRE, AND ALL INFORMATION IS HONEST, TRUTHFUL AND COMPLETE.

X_____ _____ _____
Signature of Patient, Parent or Person Responsible | Signature of Doctor | Date