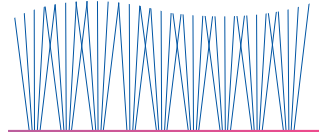


WELCOME TO OUR OFFICE



Patient Information

Date _____

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to call us at 314-961-3244. We will be happy to help you.

(Please Print)

Patient Name _____ Spouse Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Email _____

Home Phone _____ Work Phone _____ Cell _____

Sex Female Male

Are you Married Widowed Single Minor Divorced Partnered

Patient Social Security # _____ Spouse Social Security# _____

Name of person responsible for this account _____

Patient employed by _____ How long _____

Business address _____ City _____

State _____ Zip _____ Present Position _____

In case of emergency contact: _____

Phone _____ Relationship to patient _____

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

Dental Insurance Information

Name of Primary Dental Ins. _____ Group # _____

Ins. Co. Phone # _____

Name of Policy Holder _____ Relationship to patient _____

Birth date of Policy Holder _____ SSN of Policy Holder _____

Name of Employer _____ Work phone # _____

Secondary Dental Insurance Information

Name of Secondary Dental Ins. _____ Group # _____

Ins. Co. Phone # _____

Name of Policy Holder _____ Relationship to patient _____

Birth date of Policy Holder _____ SSN of Policy Holder _____

Name of Employer _____ Work phone # _____

OVER

Dental History

Name of previous Dentist _____ Date of last dental x-rays _____

Does dental treatment make you nervous? _____ No _____ Slightly _____ Moderately _____ Extremely

Have you ever been treated for Periodontal disease (gum disease, pyorrhea, trench mouth)? _____ yes _____ no

When? _____ How often do you brush? _____

How often do you floss? _____

Please check any of the following conditions that apply to you:

- | | | |
|---|--|---|
| <input type="checkbox"/> Bleeding/sore gums | <input type="checkbox"/> Unpleasant taste/bad breath | <input type="checkbox"/> Burning tongue/lips |
| <input type="checkbox"/> Frequent blisters, lips/mouth | <input type="checkbox"/> Swelling/lumps in mouth | <input type="checkbox"/> Clicking/popping jaw |
| <input type="checkbox"/> Ortho treatment (braces) | <input type="checkbox"/> Biting cheeks/lips | <input type="checkbox"/> Loose teeth |
| <input type="checkbox"/> Difficulty opening/closing jaw | <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Sensitive to sweet |
| <input type="checkbox"/> Sensitive to hot | <input type="checkbox"/> Sensitive to cold | <input type="checkbox"/> Clenching/grinding |
| <input type="checkbox"/> Sensitive to biting | <input type="checkbox"/> Food impacting | <input type="checkbox"/> Neckache |
| <input type="checkbox"/> Shifting of teeth/Change of bite | <input type="checkbox"/> Headaches | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Congested ears | <input type="checkbox"/> Ringing ears | |

Oral Hygiene

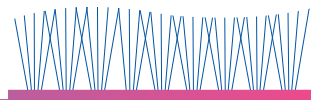
Do you use the following?

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Toothbrush | <input type="checkbox"/> Dental Floss | <input type="checkbox"/> Fluoride rinse |
| <input type="checkbox"/> Electric toothbrush | | |

Smile Assesment

Please consider each statement carefully and check mark the ones that apply to you. The doctor and members of the dental team will discuss your response with you in confidence.

- I am concerned about the appearance of my teeth or smile.
- I am concerned about the whiteness/lack of one or more of my teeth.
- I am concerned about the position or angle of one or more of my teeth.
- I am concerned about the shape of one or more of my teeth.
- In social situations, I am sometimes embarrassed by my teeth or smile.
- There are some things about my upper front teeth I would like to change.
- There are some things about my lower front teeth I would like to change.
- I have old fillings or previous dental treatment that is no longer satisfactory to me.
- I am missing one or more of my teeth.
- I am interested in learning more about aesthetic dentistry.



Medical History

Name _____

Please **list** all **medications** you are currently taking: _____

Allergies (please circle): Codeine Aspirin Penicillin Latex Erythromycin Sulfa drugs
 Anesthetic (such as Novacaine, Lidocaine, etc...)
 Other _____
 No known allergies

Have you ever been advised to Pre-medicate with an antibiotic prior to dental procedures?

Please circle: Yes or No

Name of Physician _____

Check mark any of the following that apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Embolism | <input type="checkbox"/> Nervous Problems |
| <input type="checkbox"/> Alcohol/Substance or chemical abuse | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Facial Pain / Trigeminal Neuralgia | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis/Rheumatism/Lupus (circle one) | <input type="checkbox"/> G.E.R.D. | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Artificial Heart Valve(s) (Year _____) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatment Date _____ |
| <input type="checkbox"/> Artificial Joints / Screws (Year _____) | <input type="checkbox"/> Heart attack (Year _____) | <input type="checkbox"/> Respiratory disease/Emphysema |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart or Bypass surgery (Year _____) | <input type="checkbox"/> Sexually Transmitted Disease (STD) |
| <input type="checkbox"/> Bell's palsy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sinus problems / Hay Fever |
| <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Heart conditions/irregular heart beat | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Describe _____ | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia or bleeding disorder | <input type="checkbox"/> Stroke (Year _____) |
| <input type="checkbox"/> Cold or Canker Sores | <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> Thyroid / Goiter Problems |
| <input type="checkbox"/> C.O.P.D. | <input type="checkbox"/> High Blood Pressure (Controlled) | <input type="checkbox"/> Tingling in Arms or Fingers |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Intestinal / Colitis problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease or Jaundice | <input type="checkbox"/> Ulcer(s) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Other _____ |

If you are pregnant, when is your due date? _____

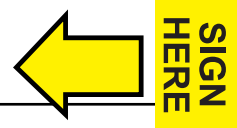
Have you ever taken any of these medications?

Blood Thinners: _____ Coumadin _____ Warfarin

Other: _____ Levoxyl _____ Synthroid

To the best of my knowledge, all of the preceding answers and information are true and correct. I understand it is my responsibility to inform the Dentist if there are any changes to my health or medications.

Signature of Patient/Guardian (or Parent) _____



OVER



Certification/Assignment and Financial Agreement

I certify I, and /or my dependent(s), have insurance coverage with _____
Name of Dental Ins. Co.

and assign directly to Dr. Weisenfels all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I also understand I am financially responsible for all charges if **I do not have dental insurance.**

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

**Please
Sign Here**

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Consent for Use and Disclosure of Personal Health Information (hippa)

This form authorizes us to use and disclose your personal health information (PHI) for the purposes of healthcare operations, treatment and payment activities.


Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact our office at:
314-961-3244 or fax 314-961-0713.

Patient's Consent

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: _____ E-mail: _____
Social Security #: ____ - ____ - ____ Date of Birth: _____

I, _____, have read your Notice of Privacy Policies and I consent to your use of my PHI for purposes of healthcare operations, treatment and payment.

X Patient Signature: _____  **SIGN HERE**

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

Personal Representatives name: _____
Relationship to Patient: _____

Acknowledgement of Receipt of Notice of Privacy Policies

I, _____, have received a copy of Dr. Kurt Weisenfels, D.D.S.'s Notice of Privacy Policies.

Name (Print) _____

X Patient Signature: _____ Date: _____  **SIGN HERE**

Financial Agreement

- 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 understand that I may incur a 12% per year finance charge if my balance goes beyond 90 days.
- I assign dental benefit payments to be paid directly to Dr. Weisenfels from my insurance company.
- I give permission for my dentist and his/her clinical team to take any necessary diagnostic films, photos, or study models to properly enable complete diagnosis and treatment.
- I understand that in the event that my account goes to collections, I am responsible for the costs of collecting the balance owed, including collection fees, attorney fees, and any incurred court costs that may apply.

Patient Signature _____

Date _____



For patients with Dental Insurance...

You may not be aware your employer may be making changes annually to your dental policy. To find out about those changes, please contact your dental insurance.

Our “recommended standard of care” is an important part of our philosophy and your optimal health. Your dental policy may or may not be in line with our philosophy.

Due to such a wide variety of dental policies, we cannot guarantee dental coverage for all services provided by us.

Thank you for providing us any changes to your policy.

We will try to be as informative as possible when it comes to your dental health and your insurance policy.