

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex: M: \_\_\_ F: \_\_\_  
 Last, First MI (Preferred Name)  
 Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Family Status: S \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_ Social Security #: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ ext:(\_\_\_\_)(Cell): \_\_\_\_\_  
 Best Place & time to call: \_\_\_\_\_ Email address: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Street Apartment #  
 City State Zip Code

### Medical/Dental Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_  
 Former Dentist: \_\_\_\_\_ Last X-Rays taken: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever had/have any of the following? Please check those that apply:

<input type="checkbox"/> AIDS / HIV	<input type="checkbox"/> Circulatory problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Hepatitis? Type _____	<input type="checkbox"/> Sensitivity
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Artificial Joints/Valves	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Skin rash
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Sores/growths in mouth
<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Food between teeth	<input type="checkbox"/> Loose/broken teeth	<input type="checkbox"/> Stroke
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Headaches	<input type="checkbox"/> Radiation treatment	<input type="checkbox"/> Tumors
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Respiratory disease	<input type="checkbox"/> Venereal Disease

Physician's Name : \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Are you now under the care of a physician? \_\_\_\_\_ If Yes, Describe: \_\_\_\_\_

Have you ever had any serious illnesses or operations? \_\_\_\_\_ If Yes, Describe: \_\_\_\_\_

Have you ever had a blood transfusion? \_\_\_\_\_ If Yes approximate date: \_\_\_\_\_

Have you required pre-medication prior to dental treatment? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_ Nursing? \_\_\_\_\_ Birth Control Pills? \_\_\_\_\_

MEDICATIONS	ALLERGIES	
List of medications you are currently taking:	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Sulfa
	<input type="checkbox"/> Barbiturates (sleeping pills)	<input type="checkbox"/> Latex
	<input type="checkbox"/> Codeine	<input type="checkbox"/> Other
	<input type="checkbox"/> Local Anesthetic	
Pharmacy: _____ Phone: _____	<input type="checkbox"/> Penicillin	
Who may we thank for referring you?		
Who should we contact in case of emergency?		

• To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

## Insurance Information

### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### PERSON RESPONSIBLE FOR PAYMENT: \_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

## Consent for Services

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit (\$55).

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. ***As a courtesy we will submit insurance claims on your behalf and we will wait up to 45 days for payment. After 45 days, we will expect payment in full. Unpaid balances, after 90 days, will be charged a financial charge of 1.5% of the total balance***

I understand that the fee estimate listed for this dental care can only be extended for a period of twelve months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within 30 days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I certify that I, and/or my dependents(s) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Weintraub all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Weintraub may use my health care information and may disclose such information to the above name insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_