This information is necessary for our files and your health and will be considered **CONFIDENTIAL.**

Patient Information

Date _____

Name _____

Mr Miss Mrs Ms Dr Marital Status: Single Married Divorced Widowed

I prefer to be called _____ E-mail _____

Address _____ (Street)

_____ (City) (State) (Zip)

Home phone _____ Work _____ Cell _____ Other _____

Birthdate _____ Social Security # _____

Employer _____ Occupation _____

Business address _____

If a patient is a minor, give parent's or guardian's name _____

Spouse's Information

Name _____

Birthdate _____ Social Security # _____

Employer _____ Occupation _____ Phone _____

Business address _____

Dental History

1. Are you having any discomfort at this time? YES / NO If yes, please describe.

   _____
2. Have you ever had any serious trouble related to previous dental treatment? YES / NO
3. Does dental treatment make you nervous? Slightly / Moderately / Extremely
4. Date of your last dental visit? _____ Treatment provided _____
5. Have you ever been treated for Periodontal Disease (gum disease, pyorrhea, trench mouth)?
   If yes, when _____ By whom _____
6. Are you satisfied with your simile? YES / NO
   If no, how would you like to improve it? _____
7. Would you like to have whiter teeth? YES / NO
   Have you ever had your teeth whitened? _____ When/How? _____
8. What are you looking for in your new Dentist? _____
9. Why did you leave your last Dentist? _____
10. What do you expect to have done during your first dental visit? _____
11. Please give the name and telephone # of the closet relative (not living with you) to contact in case of emergency.

    _____

We are almost exclusively a referral practice and we highly value those who have recommended you.
How did you hear about our office? _____

Consent for treatment: I hereby permit any treatment necessary to my dental care to include the administration of anesthetics, analgesics, sedatives, and nitrous oxide sedation, but only after these contemplated treatments and administrations have been fully and thoroughly explained to my satisfaction to include possible risks and adverse effects of both the procedures, anesthetics and drugs that may be employed. By my signature I acknowledge that I have read, understood, and accurately answered all items on this page.

Signature _____

OVER

Health History

Circle

1. Have you been a patient in the hospital during the past two years? ..... YES NO
2. Have you been under the care of a medical doctor during the past two years? ..... YES NO

Physician's Name _____

Address _____ Phone # _____

3. Have you taken any medicine or drugs during the past two years? ..... YES NO
   Are you now taking any medication, drugs or pills? ..... YES NO
   If yes, please list: _____
4. Are you allergic or have you reacted adversely to any of the following substances? ..... YES NO

Aspirin	Nitrous Oxide	Valium	Penicillin
Darvon	Enythromycin	Scopolamine	Other Antibiotics
Codeine	Tetracycine	Local Anesthetic (Novacaine or Xylocaine)	
Demerol	Percodan	Nembutal/Seconal (Sleeping pills)	
Latex Gloves	Metal allergy/Skin reaction to jewelry - What type? _____		

5. Are you aware of being allergic to any other medications or substances? ..... YES NO
   If yes, please list: _____
6. Circle any of the following which you have had or have at present:

1. Heart failure
2. Heart Disease or Attack
3. Angina Pectoris
4. High blood Pressure
5. Heart Murmur
6. Rheumatic Fever
7. Congenital Heart Lesions
8. Artificial Heart Valve
9. Heart Pacemaker
10. Heart Surgery
11. Artificial Joints (Hip, Knee / Replacement)
12. Anemia
13. Stroke
14. Kidney Trouble
15. Ulcers
16. Cosmetic Surgery
17. Emphysema
18. Cough
19. Tuberculosis (TB)
20. Asthma
21. Hay Fever
22. Sinus Trouble
23. Allergies or Hives
24. Diabetes
25. Thyroid Disease
26. X-ray or Cobalt Treatment
27. Chemotherapy (Cancer, Leukemia)
28. Arthritis
29. Rheumatism
30. Cortisone Medicine
31. Glaucoma
32. Pain in Jaw Joints
33. Frequent Headaches
34. A.I.D.S./HIV
35. Hepatitis A (infectious)
36. Hepatitis B (serum)
37. Liver Disease
38. Yellow Jaundice
39. Blood Transfusion
40. Drug Addiction
41. Hemophilia
42. Venereal Disease (Syphilis, Gonorrhea)
43. Cold Sores/Fever Blisters
44. Epilepsy or Seizures
45. Fainting or dizzy Spells
46. Nervousness
47. Sickle cell Disease
48. Psychiatric Treatment
49. Bruise Easily
50. Periodontal (Gum) Disease
51. High Decay Rate ("Soft Teeth")
52. Poor Occlusion (Bad Bite)
53. Tobacco Use
54. Mitral Valve Prolapse
55. Family History of:
    ____ Diabetes
    ____ Heart Disease
    ____ Poor Gums
    ____ Soft Teeth
    ____ Other _____
56. Poor Nutrition
57. Any Other Health Problems Not Included
    _____

CIRCLE ONE

7. Do you have dry mouth? ..... Yes No
8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... Yes No
9. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
10. Are you on a special diet? ..... Yes No
11. Have you ever taken any appetite suppressant, fen fen or other to aid in weight loss? If so, specify name of medication ..... Yes No
12. Has your medical doctor ever said you have cancer or a tumor ..... Yes No
13. Do you have a disease, condition or problem not listed? ..... Yes No

FOR WOMEN ONLY:

Are you pregnant? YES/NO If yes, what month? _____
Are you taking birth control pills? YES/NO

All questions asked on this history form are important in arriving at a diagnosis and a treatment plan; all questions must be answered: if a medical condition not related to any other questions on this form is known, it should be reported to the Doctor. I have read, understood and complied with this request to the best of my ability. If any change occurs in my health or in any of the information provided above I will report it to the dental office as soon as possible.

Patient Signature: _____ **Date** _____

David J. Weinstock, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES—HIPAA

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of same. You may refuse to sign this acknowledgement form.

By signing this form, I confirm that I have received a copy of the office Notice of Privacy Practices.

Print name_____

Signature_____

Date_____

Written acknowledgement was not obtained.

_____ **Patient refused to sign**
_____ **Emergency Situation**
_____ **Unable to communicate with patient**
_____ **Other** _____

Financial and Insurance Policy

We do not participate with any insurance plans. Therefore, our financial contract is with you, our patient. Our office will assist in processing insurance claims to the extent that time permits. We expect covered patients to read their policies carefully and to become familiar with benefits and limitations. It is important to understand that dental insurance is designed to reduce cost, not eliminate it entirely. Please note that pre-authorization estimates of insurance benefits are estimates only. Dealing with insurance companies has become a very time consuming process. Therefore, please personally notify your insurance company if you do not received reimbursement within 30 days of your office visit. Our office is not responsible for insurance policy determinations or decisions rendered by the insurer. You remain financially responsible for your dental care. However, we will be happy to submit claim forms to your insurance company if you will please provide us the following information:

Name of Policy Holder:
Policy Holder's Social Security Number:
Policy Holder's Date of Birth:
Name of Employer:
Group Name:
Group Number:
Insurance Co. Name (Dental Only):
Insurance Co. Address:

We require payment at the time of service for all treatment unless other arrangements have been made in advance with our Office Manager. Patients with treatment over $500.00 are expected to set up payment arrangements prior to the start of treatment. For your convenience, we accept cash, check, Visa, Discover, Master Card and American Express.

Unless prior arrangements have been made, accounts unpaid after 30 days from the date of billing are subject to a finance charge of 1% per month (12%) per annum. If your account is referred for collection, you will be responsible for collection costs and attorney fees.

Attorney fees. In the event that any legal action is commenced with regards to the subject matter of this Service Agreement (including nonpayment by Patient), the parties specifically agree that the prevailing party in such action shall be entitled to have its reasonable attorney's fees, filing fees, and other costs incurred in said action fully reimbursed by the non-prevailing party.

Appointments cancelled with less than 24 hours notice are subject to a cancellation fee of $75.00. Returned checks are subject to a $25.00 processing charge. If you have any questions about this policy or your account, please speak to our Office Manager.

I have read and understand the above statements and have ample opportunity to discuss any of this information with Dr. Weinstock and/or members of his staff. I accept the above terms.

Date: ___/___/___ Patient/Guardian _____