PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

City State Zip:

Email:

Home Phone:

Work Phone:

Cell Phone:

Birth Date:

Social Security No.:

Marital Status:

Primary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

Secondary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

Physician Name:

Physician Phone:

Pharmacy:

Pharmacy Phone:

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only
BP Heart Rate:

Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I HAVE READ AND/OR RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES

_____

PRINT PATIENT NAME

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

_____

DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- **Individual refused to sign**
- **Communication barrier prohibited obtaining**
- **An emergency situation prevented obtaining**
- **Other (please specify):**

  _____

DR. DANA WEINREICH & ASSOCIATES FAMILY DENTISTRY

FINANCIAL AND CANCELLATION POLICY

As a courtesy to our patients, we are happy to submit your dental claims to your insurance carrier. In addition, we will wait up to six (6) weeks for your carrier to pay your estimated claim amount. All insurance claims filed are required to be paid in full within sixty (60) days of the date of service **regardless** of whether your carrier has paid your dental claim. This means as a patient of record, you are ultimately responsible to pay your balance in full **IF** the practice has received payment from your insurance carrier within 60 days of the date of service. Many dentists do not offer this courtesy the patient must normally pay in full in advance and wait for reimbursement from their insurance carrier.

Insurance is designed to offset the cost of your dental care. It does not (in most cases) pay the full cost of services rendered. We do collect your **estimated** patient portion on the day that the service(s) is performed. We try as best as possible to estimate what your insurance will cover on your submitted claim; **however,** it is only an estimate. Patient portions cannot be fully determined until the claim has been processed and paid in full by your insurance carrier. Therefore, should there be a discrepancy between the estimated amount figured by this office and what has actually been paid by your insurance carrier, the remaining unpaid portion will be due from the patient within **10 days** of the practice receiving the insurance payment. We do issue statements both via email and USPS if there is additional money owed on the day that your insurance check is posted to your account. Whether or not you have received your email or mailed statement, the patient is responsible for their balance.

Dental insurance is a contract between the patient, patient's employer, and the insurance carrier and all charges are ultimately the patient's responsibility.

Patients without dental insurance agree to full responsibility of the total payment of all procedures performed at this office. Those procedures are to be paid in full at the time the services(s) are rendered.

Additionally, we reserve the right to charge a $50 fee for appointments missed (no-showed) or cancelled without 24-hour notice.

Print Patient Name:_____

Signature of Patient or Responsible Party:_____

Date:_____

Dental Insurance Information

Patient Name:_____ **Date of Birth:**_____

Subscribers Name:_____ **Date of Birth:**_____

Subscribers ID/Social Security #_____

Primary Insurance Co:_____

Group #_____ **Effective Date:**_____

Ins. Co. Address:_____

Ins. Co. Phone #_____ **Insured's Employer**_____

Do You Have Dual Coverage? Yes or No (If yes complete below)

Insureds Name:_____ **Date of Birth:**_____

Insured's ID/Social Security #_____

Secondary Ins. Co._____

Group #_____ **Effective Date:**_____

Ins. Co. Address:_____

Ins. Co Phone #_____ **Insured's Employer**_____

As a courtesy, claims may be filed on my behalf

Signature:_____ **Date:**_____