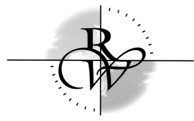

RICHARD D. WEIGAND, DDS

The benefits of a happy, beautiful smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Name ____________________

I prefer to be called: ____________________ Male Female

Birthdate: __________ S.S.# __________

Home Address: ____________________

____

Hm # __________ Pager/Cell # __________

Wk # __________ Email __________

Employer ____________________

Employer's Address: ____________________

____

Occupation: ____________________

Whom may we thank for referring you? ____________________

Other family members seen by us? ____________________

Previous/Present Dentist: ____________________

Last Visit Date: __________ Ph # __________

In the event of an emergency, whom should we contact?

____

Wk #: __________ Hm #: __________

Medical History

Do you have or have you had any of the following?

- ❑ Angina
- ❑ Heart murmur
- ❑ Taking heart medication
- ❑ Pacemaker
- ❑ Taking Coumadin or Anticoagulants
- ❑ Taking any medication or drugs
- ❑ Blood pressure problems
- ❑ Heart valve problem requiring premedication
- ❑ Abnormal bleeding
- ❑ Asthma
- ❑ Joint replacements (total hip, pins, or implants)

Woman:

- ❑ Taking Birth Control Pills
- ❑ Are you pregnant? How many weeks: __________

Are you allergic to or have you reacted adversely to any of the following:

- ❑ Local Anesthetics
- ❑ Sulfa drugs
- ❑ Codeine or other narcotics
- ❑ Reaction to metals
- ❑
- ❑ Penicillin or other antibiotics
- ❑ Aspirin, Acetaminophen or Ibuprofen
- ❑ Latex or Rubber Dam

Other: ____________________

Misc. Concerns:

- ❑ Diabetes
- ❑ Fainting spells
- ❑ Do you smoke or chew tobacco
- ❑ HIV / AIDS
- ❑ Cancer / Tumor
- ❑ Seizures or Epilepsy
- ❑ Sexually Transmitted Diseases

Primary Dental Insurance

Insurance Co. Name ____________________

Insurance Co. Address: ____________________

Insurance Co. Phone #: ____________________

Group $ (Plan, Local or Policy #): ____________________

Insured's Name: __________ Relation: __________

Insured's Birthdate: __________ Insured's S.S.#: __________

Insured's Employer: ____________________

Secondary Dental Insurance

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

Insurance Co. Phone # ____________________

Group # (Plan Local or Policy #): ____________________

Insured's Name: __________ Relation: __________

Insured's Birthdate: __________ Insured's S.S. # __________

Insured's Employer: ____________________

How would you describe the condition of your teeth or gums?

____

Are you currently in pain or discomfort with your teeth or gums?

____

Explain: ____________________

How often do you brush your teeth?

____

Do your gums bleed when you brush?

____

How often do you floss your teeth?

____

Do your gums bleed when you floss?

____

Have you ever experienced pain in your jaw joint?

I understand that the information is correct to the best of my knowledge and it will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status.
I authorize the release of information for insurance purposes and give consent for Dr. Weigand and his staff to treat me.
I authorize Dr. Weigand and/or his staff to take photographs of my care and treatment, which may be used for the advancement and educational viewing by other dentists, staff or patients. Dr. Weigand and his staff cannot reveal my identification without my permission.

I am responsible for payment.

Signature:: ____________________ *Date:* __________