Bruce A. Weitz, D.D.S. Inc.
1700 Cooper Foster Park Road, Suite B
Lorain, OH 44053
Tel: 440-282-1396

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

PATIENT INFORMATION

Date _____ Social Security # _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City, State, Zip _____

Sex ○ M ○ F ○ Married ○ Widowed ○ Single ○ Minor
○ Separated ○ Divorced ○ Partnered for _____ years

E-mail _____ Cell Phone _____

Employer/School _____ Employer/School Phone No. _____

Employer/School Address _____ City, State, Zip _____

Spouse/Parent Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Responsible Party _____ Relation to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone _____

Currently a patient in our office? ○ Yes ○ No E-mail _____ Phone _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City, State, Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City, State, Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City, State, Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City, State, Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____ City, State, Zip _____

Check if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ○ Yes ○ No

Have you had any serious illnesses or operations? ○ Yes ○ No If yes, describe _____

Have you ever had a blood transfusion? ○ Yes ○ No If yes, describe

(Women) Are you pregnant? ○ Yes ○ No Nursing? ○ Yes ○ No Taking birth control? ○ Yes ○ No

Check if you have had problems with any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking and the correlating diagnosis

Allergies:

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health,

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ 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.

The above-mentioned dentist 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. This consent will end when the current treatment plan is complete or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

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

Payment is due in full at time of treatment unless prior arrangements have been approved.