

Texas Wisdom Teeth and Dental Implants  
Robert A. Weinstein, DDS, MS

Today's Date: \_\_\_\_\_

PatientName \_\_\_\_\_ StreetAddress \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_-\_\_\_\_-\_\_\_\_ Age \_\_\_\_\_

Sex M / F SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ DL# \_\_\_\_\_ State \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Place of Employment or School name \_\_\_\_\_

**Emergency Contact Information:**

Name \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Have you or another family member been a patient in our office before? Y / N If yes, Name \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Name and phone # of your general dentist \_\_\_\_\_

Name and phone # of your physician \_\_\_\_\_

**What is your primary reason for visiting us today?** \_\_\_\_\_

Can we provide you with information about any other oral health concerns? (I.e.: dental implants, TMJ, Corrective Jaw Surgery)

\_\_\_\_\_

How would you rate your overall oral health?

1	2	3	4	5	6	7	8	9	10
Poor								Excellent	

How important is your oral health to you?

1	2	3	4	5	6	7	8	9	10
Not Important								Very Important	

**Insurance Information:** We are happy to file up to two insurance claims for you at no charge. You may be asked to pre-pay an estimated portion of the total charge based on your coverage. Any portions of your treatment costs which are not ultimately paid or covered by your insurance, regardless of the reasons why are your sole responsibility.

**Dental Insurance Company Name** \_\_\_\_\_

Insurance Phone# \_\_\_\_\_ Group # \_\_\_\_\_ Insured's ID/SS# \_\_\_\_\_

Insured's name and DOB \_\_\_\_\_

**Medical Insurance Company Name** \_\_\_\_\_

Insurance Phone# \_\_\_\_\_ Group # \_\_\_\_\_ Insured's ID/SS# \_\_\_\_\_

Insured's name and DOB \_\_\_\_\_

**How do you plan to pay for your services today?**

Cash Check Visa MasterCard Discover AMEX Care Credit CitiHealthCard

I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES ARISING FOR SERVICES DELIVERED AND I AUTHORIZE PAYMENT OF ANY MEDICAL/DENTAL INSURANCE BENEFITS TO DR. ROBERT A. WEINSTEIN. I AUTHORIZE THE RELEASE OF ANY INFORMATION PROVIDED IN MY MEDICAL/DENTAL RECORDS NECESSARY TO PROCESS MY CLAIM. I ATTEST THAT THE INFORMATION PROVIDED IN THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# HEALTH HISTORY

Patient's Name \_\_\_\_\_
Date of Birth \_\_\_\_\_
Date \_\_\_\_\_

**Answer all questions by circling Yes (Y) or No (N)**

**All responses are kept confidential**

1. Are you in good health? .....Y N
2. Has there been any change in your general health in the past year? .....Y N
3. Date of last physical exam \_\_\_\_\_
4. Are you now under a physician's care for a particular problem? .....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: .....Y N

- G. Insulin or Oral Anti-Diabetic drugs? .....Y N
- H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
- I. Are you taking or **have you ever taken** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa) ? .....Y N
- J. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: \_\_\_\_\_

6. Height \_\_\_\_\_ Weight \_\_\_\_\_

7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
  - A. Rheumatic Fever or Rheumatic Heart Disease? ....Y N
  - B. Congenital Heart Disease? .....Y N
  - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) .....Y N
  - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .....Y N
  - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness.....Y N
  - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?.....Y N
  - G. Liver Disease (Jaundice, Hepatitis)?.....Y N
  - H. Kidney Disease? .....Y N
  - I. Diabetes? .....Y N
  - J. Thyroid Disease (Goiter)? .....Y N
  - K. Arthritis?.....Y N
  - L. Stomach Ulcers or Colitis?.....Y N
  - M. Glaucoma?.....Y N
  - N. Osteoporosis .....Y N
  - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .....Y N
  - P. Radiation (X-ray) treatment for Cancer? .....Y N
  - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? .....Y N
  - R. Sinus or Nasal problems? .....Y N
  - S. Any disease, drug or transplant operation that has depressed your immune system?.....Y N

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
  - A. Local Anesthesia (Novocain, etc.)? .....Y N
  - B. Penicillin or other antibiotics? .....Y N
  - C. Sedatives, Barbiturates? .....Y N
  - D. Aspirin or Ibuprofen?.....Y N
  - E. Codeine or other pain killers? .....Y N
  - F. Latex or Rubber Products? .....Y N
  - G. Other allergies or reactions? Please, list.....Y N

10. Do you smoke or chew Tobacco?.....Y N  
How much per day? \_\_\_\_\_
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .....Y N
12. Have you had any serious problems associated with any previous dental treatment?.....Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia?.....Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .....Y N
15. Do you wish to talk to the doctor privately about anything? .....Y N

8. **ARE YOU USING ANY OF THE FOLLOWING:**
  - A. Antibiotics?.....Y N
  - B. Anticoagulants (Blood Thinners)?.....Y N
  - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.....Y N
  - D. High Blood Pressure medications?.....Y N
  - E. Steroids (Cortisone, etc.)? .....Y N
  - F. Tranquilizers .....Y N

16. **FOR WOMEN ONLY**
  - A. Are you Pregnant, or **is there any chance** you might be Pregnant?.....Y N
  - B. Are you nursing?.....Y N
  - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

**I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.**

Date \_\_\_\_\_
Signature of Person Completing Health History \_\_\_\_\_
Doctor's Initials \_\_\_\_\_

**Medical Update:** I have ready my Health History dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

Date \_\_\_\_\_
Exceptions or changes \_\_\_\_\_
Patient's Signature \_\_\_\_\_
Doctor's Initials \_\_\_\_\_

Date \_\_\_\_\_
Exceptions or changes \_\_\_\_\_
Patient's Signature \_\_\_\_\_
Doctor's Initials \_\_\_\_\_