LEONARD A WEISS, DMD
A Smile for Your Lifetime

DENTAL REGISTRATION AND HISTORY
(Please Print)

Date ______________________ Home Phone (_____) ___________________________ Cell (______) _____________________

PATIENT INFORMATION

Name ____ SS/HIC/ Patient ID # _________________________
Last Name First Name Middle Initial

Address ____

City ____ State ___________ Zip ______________________

Sex ☐ M ☐ F Age ________ Birthdate ___________ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _________years

Patient Employer/ School _______________________________ Occupation _______________________________

Employer/ School Address _______________________________ Employer/ School Phone (______) ________________

Whom may we thank for referring you? ____

In case of emergency who should be notified? ____________________________ Phone (_____) ______________________________

PRIMARY INSURANCE

Person Responsible for Account ____
Last Name First Name
Middle Initial

Relation to Patient __________________ Birthdate _____________________ Soc. Sec. # _________________________________

Address (If different from patient's) __________________________________ Phone (_______) ______________________________

City ____ State ________ Zip ______________________

Person Responsible Employed by ____________________________________ Occupation ____________________________

Business Address ____ Business Phone (______) ______________________

Insurance Company ____

Contract # _________________________ Group # _____________________ Subscriber # _________________________________

Names of other dependents covered under this plan ____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _________________________ Birthdate _____________ Relation to Patient ___________________________

Address (If difference from patient's) _________________________________ Phone (_______) ____________________________

City ____ State ______________ Zip ____________________

Subscriber Employed by ____ Business Phone (_______) _______________________

Insurance Company ____ Soc. Sec. # ________________________________

Contract # ______________________________ Group # ________________ Subscriber # _________________________________

Names of other dependents covered under this plan ____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________________ and assign directly to
Name of Insurance Company(ies)

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-named doctor 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 my current treatment plan is completed or one year from the date signed below.

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

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DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit ________________________ Date of last dental care ________________________

Former Dentist________________________ Date of last dental X-rays ________________________

Address ____

Check (✓) if you have had problems with any of the following

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between 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 Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Have you had any serious illnesses or operations? ________________ If yes, describe ________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ________________

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

Check (✓) if you have or have had any of the following

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ 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

MEDICATIONS

List medications you are currently taking:

____

____

Pharmacy Name ________________________________

Phone (_____) ________________________________

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex ________________
- ☐ Other ________________

____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ________________________ Signature ________________________________

10019 Cleary Boulevard
Plantation, Florida 33324
Phone (954) 473-6400
Fax (954) 473-0594
www.leonardweissdmd.com

FINANCIAL POLICY FOR PATIENTS

Thank you for choosing "Leonard A. Weiss, D.M.D., PA." as your preferred dental health care provider. Our office is conformed of highly professional and experienced personnel, committed to provide you with the best possible dental care to fit your particular needs.

The following is a statement of our Financial Policy which we ask that you read, agree to, and sign, prior to treating you.

PAYMENT IN FULL IS DUE ON THE DAY SERVICE IS RENDERED

WE ACCEPT INSURANCE, CASH, CHECK, VIA MASTERCARD, DISCOVER—WITH PRIOR CREDIT APPROVAL, WE ALSO OFFER AN EXTENDED PAYMENT PLAN.

REGARDING INSURANCE

As a courtesy to you, we will gladly fill out and file your insurance claims with your insurance company for you; however, pleas understand that you will be responsible for paying any balance remaining after your insurance company has paid, or has declined payment for any portion of your charges for whatever reason. Our fees generally fall into the acceptable range considered by most companies to be "usual, customary & reasonable" for this region; however this does not apply to those companies that reimburse based on an arbitrarily select certain services they will not cover at all. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

PAYMENT FOR SERVICES

AT TIME OF SERVICE, all patients (or guardians or parents of minors) are responsible for Payment in Full, by Insurance, Cash, Visa, Master Card, Discover or the Extended Payment Plan (with prior approval as required) for all insurance co-payments, insurance deductibles, and any other charges not expected to be recovered through the patients insurance.

REQUIREMENTS FOR PAYMENT IN ADVANCE

At least 50% of any dental procedure which requires laboratory services must be paid prior to impression being taken or orders being sent to a dental laboratory for work. All crowns, bridges, dentures, and other laboratory services or fabricated devices must be paid in full before they will be installed.

Thank you for the understanding of our financial policy. Please let us know if you have any questions or concerns. We are here to help you.

I have read, understood, and agree to the above Financial Policy.

Patient Name: ____

Patient or Financially Responsible Party: ______________________ Date: _______________

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PATIENT INFORMATION REGARDING BROKEN APPOINTMENTS

There will be a **$40.00** charge fee for all broken appointments, which are not cancelled within 24 hours of your scheduled visit. This does NOT apply to cases of emergency. This charge is **YOUR** responsibility and payment is expected in full. (Please note: We will **NOT** bill any insurance company for this amount.)

I HAVE READ AND UNDERSTAND THE ABOVE REFERENCED POLICY.

______________________________ ____________________

(Signature: patient/parent/guardian) Date

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, ______________________________, have reviewed/ received a copy of

__Leonard A. Weiss, DMD, PA__ 's Notice of Privacy Practices.
Practice Name

____________________________________ ____________________________
Signature of Patient/ Guardian Date

OFFICE USE ONLY

I attempted to obtain the patient's signature on acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason

I authorize the dental office to leave a message at my home advising of my dental appointments. This will include leaving a message on answering machine devices or with family members or living partners.

I further authorize the dental office to mail postcards to my home advising me of my dental appointments or the need to call for an appointment.

____
Patient or Patient's Guardian