



Michael Weiss, DDS
COSMETIC DENTISTRY
Accredited Member of American Academy
of Cosmetic Dentistry

DATE

Email

Last

First

Middle Initial

Ms. ☐ Mrs. ☐ Mr. ☐ Dr. ☐

Address

Home
Phone

Business

Cell

City

State

Zip

Birthdate

Male ☐

Female ☐

Primary Dental Insurance

Yes ☐

No ☐

Insurance Coverage Through?

Self ☐

Parents ☐

Spouse ☐

Insured's Name

Insured Place of Employment

Insured's ID #

Insured's Birthdate

Insured's Group #

Insurance Company Name

Insurance Phone #

Insurance Address

Is there anything about
your smile that you
would like to
change?

YES

NO

If YES, what would you change?

Do you have
Secondary
Dental Insurance?

YES

NO

Insurance Co. Name, Address & Phone #

Group #

Employee ID #

Employee Name & Birthdate

Place of Employment

Emergency Contact

Name

Phone Number

Physician Name

Physician Address

Physician Number

Whom may we thank for your
referral?

Please complete BOTH sides.

OVER

If you have ever had or
currently have the following
please check if yes:

☐ Diabetes

☐ Hepatitis A-B-C-D-E-F

☐ Cancer

☐ Liver Disease

☐ Arthritis

☐ Sinus/Hay Fever

☐ Asthma

☐ Ulcers

☐ Kidney Disease

☐ Tuberculosis

☐ Artificial Joints

☐ Premed

☐ Epilepsy

☐ Abnormal Bleeding

☐ AIDS/HIV

☐ TMJ (jaw joints) problems

☐ Headaches

☐ Fainting

☐ Immunosuppressive
Disorders

☐ Anemia

☐ Head and Neck Surgery

☐ Head and Neck Tumors

☐ Blood Disorders

☐ A-Fib

☐ Chemo or Radiation
Therapy

☐ Thyroid Problems

☐ Psychiatric Problems

☐ Nervous Disorders

☐ Heart Murmur

☐ Premed

☐ Heart Attack

☐ Stroke

☐ Pacemaker/Defibrillator

NONE



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Allergies	<input type="checkbox"/> Novocain/Epinephrine/Anesthetics	For women
Check all that apply	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Are you pregnant? <input type="checkbox"/> Are you nursing?
	<input type="checkbox"/> Antibiotics	
	<input type="checkbox"/> Latex/Rubber	
	<input type="checkbox"/> Sedatives	
	<input type="checkbox"/> Codeine	
	<input type="checkbox"/> Other:	
<input type="checkbox"/> Sulfa Drugs	<div>NONE</div>	
<input type="checkbox"/> Aspirin		

Medications	<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Steroids	<input type="checkbox"/> Aspirin
	<input type="checkbox"/> Diabetic Medications	<input type="checkbox"/> Bisphosphonates (Osteoporosis)	<input type="checkbox"/> Heart Medication	<input type="checkbox"/> Sulfa
	<input type="checkbox"/> Blood Thinners	<input type="checkbox"/> Nitroglycerin/ Nitro Patch	<input type="checkbox"/> Cortisone	
	<input type="checkbox"/> Blood pressure medications	<input type="checkbox"/> Pain Medications	<input type="checkbox"/> Anti-histamines	

Please list your medications. Include non-prescription and vitamins.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I understand that I am responsible for all costs of my dental treatment. I hereby authorize release of any information, including the diagnostics and records of treatment or examination to be rendered to my insurance company.

Signature

Date

Medical History Update

I have read my medical history and confirmed that it states past and present medical conditions.

Signature

Date

I have read my medical history and confirmed that it states past and present medical conditions.

Signature

Date

I have read my medical history and confirmed that it states past and present medical conditions.

Signature

Date