Melvin J. Weissburg D.M.D., P.A.

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Office: (301) 498-3636 Fax: (301) 498-4536

Patient Name: _____

Street:_____

City: _____ State:_____ Zip Code: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Email: _____

Sex: Male ☐ / Female ☐ Date of Birth: _____/_____/_____ Social Security # : _____

Employer:_____ Occupation:_____

How long have you been at your Present Employer?_____

Referred by: _____ **General Dentist**:_____

Address or Phone #:_____

Dental Insurance Name:_____
Relationship to insured: Self ☐ / Spouse ☐ / Child ☐

Member ID: or SSN:_____ Group #: _____

If Insured is other than self, please complete the following:

Insured person's name: _____ Date of Birth:_____/_____/_____

Method of Payment other than Insurance: (please circle) Cash / Check / Credit card

- **There will be a <u>$120.00</u> charge for all failed or broken appointments without 24 hours' notice.**
- **Payment is expected in full at the time of service.**
- **Finance charges of 1 ½ % per month for accounts will be added if the balance is 30 days past due.**
- **Accounts sent to collections will have a collection fee of 15% added to the balance.**

I, the undersigned, understand and take full responsibility for all of the above information. I understand that I am responsible for any and all fees that are accrued in this office and are not covered by my insurance company.

_____ _____

signature of patient or legal guardian date

PLEASE COMPLETE BACK OF FORM

To help give you the best treatment, please complete the following about your medical history.
This information is strictly confidential and will not be released to anyone else.

Dental History

How long has it been since you have seen a dentist?_____

Are you apprehensive about dental treatment? Yes / No

Would you be interested in receiving oral sedation for your visit? Yes / No

Are your teeth (in general) sensitive to hot/cold, sweets, or pressure? **Circle all that apply**

Medical History

Do you have any current health problems?_____
Are you under a physicians care now? Yes / No
If yes, for what? _____

What medications are you currently taking?_____
Do you think you may be pregnant? Yes / No

Check any of the following, which you presently have, or have had:

___ low blood pressure	___ diabetes	___ heart murmur
___ high blood pressure	___ anemia	___ allergies
___ rheumatic fever	___ kidney trouble	___ hepatitis B
___ heart pacemaker	___ stroke	___ mitro valve prolapsed
___ emphysema	___ bruise easily	___ tuberculosis
___ bleeding problems	___ HIV positive	Do you pre-medicate? Yes / No
___ asthma	___ heart disease	

Other:_____

Check if you are allergic to or have reacted adversely to any of the following:

___ aspirin	___ erythromycin	___ local anesthetic
___ penicillin	___ sulfa meds	___ codeine
___ latex	___ nitrous oxide	Other:_____

I, the undersigned, consent to the doctor performing any examination indicated and any other procedures deemed necessary. I understand that I have the right to refuse treatment after the initial examination. I have the right to have the tooth or teeth extracted. I understand that if any initial root canal treatment is performed, I must notify the office of Dr. Weissburg if the temporary filling comes out. I understand that failure to do so may result in re-infection of the tooth. I further understand that I must make an appointment with my general dentist, immediately after treatment is completed, to arrange for permanent restorations in the treated teeth. Failure to do so can lead to re-infection. I, the undersigned, have read and understood all of the above information and consent to the performing of root canal therapy if it is required.

Signature: _____ Date: _____