



Weinstein & Della Bella

Esthetic and Preventive Family Dentistry
7835 Remington Road
Cincinnati, Ohio 45242

Medical Alert

We are pleased to welcome you to our practice. Thank you for selecting our office for your dental care. Please take a few moments to fill out the four sections of this form as completely as you can. We look forward to working with you in maintaining your dental health.

Section 1

Today's Date _____

Name: _____
Last First I Prefer To Be Called

Address: _____
Street City State Zip

Home Telephone Number: _____ Cell Number: _____ Pager Number: _____

Personal Information: (This personal information will help us to give you the most consideration of your time and feelings. It is important to have complete answers. All information is, of course, considered confidential.)

Occupation: _____ Social Security Number _____ Date of Birth _____

For what company do you work? _____ Business telephone & ext. _____

Business Address: _____
Street City State Zip

If student, school: _____

Circle if you are: Single, Married, Widowed, Separated, Divorced. First Name, Spouse: _____ S.S. No. _____

Occupation of Spouse: _____ For what company does your spouse work? _____

Spouse's Business Address: _____
Street City State Zip

Spouse's Business Telephone No. _____ Ext. _____

Physician's Name: _____ Address: _____ Tel. No. _____

Person responsible to payment of bill: _____

If you are under 18, or not responsible for payment of bill: _____

Mother's Name _____ Occupation: _____ Phone: _____ S.S. No. _____

Where does she work? _____

Father's Name _____ Occupation: _____ Phone: _____ S.S. No. _____

Where does he work? _____

2. Insurance Information

Are you covered by any kind of dental insurance? Yes _____ No _____

Name of insurance company: _____

Name of Employer: _____

Address of Insurance Company: _____

Name of Subscriber: _____

Group # _____ Birthday: _____

Dependents:

Name(s): _____ Birthday(s): _____

Name(s): _____ Birthday(s): _____

Release and Assignment:

I certify that I am covered by insurance with (Name of Insurance Company) _____ and assign directly to Dr. Weinstein or Dr. Della _____ 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 hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance transmissions for myself and those of my dependents listed above.

Signature of responsible party

Relationship

Date

3. Dental and Family History

Are you aware of any particular dental problems? _____

Are you having any discomfort or pain? _____

Have you ever had any problems with your Temporomandibular (Jaw) Joint? _____ If yes, describe _____

Do you regularly wake up with headaches? _____

Do you have insomnia? _____ Do you snore? _____

How long has it been since you last visited a dental office? _____

What was done for you at that time? _____

May we ask who recommended this office? _____

Do you have a family history of: Heart Disease? _____ T.B.? _____ Diabetes? _____
 Cancer? _____ High Blood Pressure? _____

Do you smoke? _____ If so, what and how much/day? _____

How often do you consume alcoholic beverages? Circle one: None, 1-5 drinks/week, 6-10, 10 or more _____

Present health status of immediate family: _____

Which, if any sports do you regularly participate in? _____

4. Medical History

1. Has there been any problem in your general health within the past 5 years? _____
 If yes, please explain: _____

2. Date of last physical examination? _____

3. Are you currently under the care of a physician? _____
 If so, please explain: _____

4. Are you taking any drug of medicine? _____ If so, what? _____

Do you have or have you had any of the following diseases or problems, please circle yes or no, please circle the disease or illness that applies to you.

Mitral Valve Prolapse.	Yes	No	Have you ever been told you are HIV positive?	Yes	No
Heart Murmur.	Yes	No	Has a member of the medical profession diagnosed you as having or treated you for Acquired Immune Deficiency Syndrome (AIDS)	Yes	No
Rheumatic fever, rheumatic heart disease.	Yes	No	Sensitive or allergic to: Please Check. Penicillin _____ Sulfa _____ Novacaine _____ Codeine _____ Aspirin _____ Anesthetics _____ Other _____		
Other heart trouble, heart attack, High Blood Pressure, Stroke.	Yes	No	Sensitive or allergic to any metals, Jewelry?	Yes	No
Pain in chest, shortness of breath, swollen ankles.	Yes	No	Sensitive or allergic to any foods?	Yes	No
Are you wearing a pacemaker?	Yes	No	What? _____		
Do you have any type of joint replacement?	Yes	No	Do you have stomach ulcers?	Yes	No
What? _____			Are you wearing contact lenses?	Yes	No
Has your physician ever suggested that you have antibiotic premedication for dental procedures?	Yes	No	Do you have any other diseases or problems?	Yes	No
Blood disorders, anemia.	Yes	No	If so what? _____		
Blood test with unusual results.	Yes	No	Women, are you pregnant?	Yes	No
Abnormal bleeding, prolonged healing, bruises easily.	Yes	No	Persistent cough, cough up blood.	Yes	No
Low Blood Pressure?	Yes	No	Radiation, surgery, or drug treatment for a tumor or growth?	Yes	No
Fainting spells, seizures or epilepsy?	Yes	No	Sores that did not heal within one week?	Yes	No
Hepatitis (type), jaundice, liver disease.	Yes	No	Tuberculosis, other lung ailments.	Yes	No
Arthritis.	Yes	No	If so, what? _____		
Kidney troubles?	Yes	No	Diabetes?	Yes	No
If so, what? _____			Parents Signature _____		

Have there any been any changes in the previously listed medical history?
 Yes _____ No _____ Date _____ Signature _____

Comments _____

Yes _____ No _____ Date _____ Signature _____

Comments _____