Richard D. Weigand, DDS

The benefits of a happy, beautiful smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Name: _____

I prefer to be called: _____ Male ☐ Female ☐

Birthdate: _____ S.S.#: _____

Home Address: _____

City:_____ State: _____ Zip:_____

Hm#: _____ Cell#: _____

Wk#: _____ Email: _____

Employer: _____

Occupation: _____

Whom may we thank for referring you? _____

Previous/Present Dentist: _____

Date of last visit: _____ Ph#: _____

Emergency Contact: _____

Emergency Contact Number: _____

Physicians Name: _____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: _____Insured's S.S.#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: _____Insured's S.S.#: _____

Insured's Employer: _____

Health Information: Have you ever had any of the following:

Yes ☐ No ☐ **Do you smoke?**
Yes ☐ No ☐ **Do you chew tobacco?**
Yes ☐ No ☐ **History of chemical dependency/alcoholism?**
Yes ☐ No ☐ **HIV Positive/AIDS?**
Yes ☐ No ☐ **Sexually Transmitted Disease?**
Yes ☐ No ☐ **Herpes Simplex Virus?**
Yes ☐ No ☐ **Arthritis?**
Yes ☐ No ☐ **Joint replacement (total hip, pins, or implants)?**
Yes ☐ No ☐ **Angina?**
Yes ☐ No ☐ **Heart Valve problem requiring premedication?**
Yes ☐ No ☐ **Pacemaker?**
Yes ☐ No ☐ **Blood pressure problems?**
Yes ☐ No ☐ **Taking Coumadin or anticoagulants?**
Yes ☐ No ☐ **Heart disease?**
Yes ☐ No ☐ **Abnormal bleeding?**
Yes ☐ No ☐ **Stroke/TIA?**
Yes ☐ No ☐ **Respiratory Problems?**
Yes ☐ No ☐ **Asthma?**
Yes ☐ No ☐ **Tuberculosis?**
Yes ☐ No ☐ **Sinus problems?**
Yes ☐ No ☐ **Anxiety?**
Yes ☐ No ☐ **Depression?**
Yes ☐ No ☐ **Mental disorders?**
Yes ☐ No ☐ **Epilepsy/seizures?**
Yes ☐ No ☐ **Dizziness/fainting?**
Yes ☐ No ☐ **Cancer/tumors?**
Yes ☐ No ☐ **Kidney disease?**
Yes ☐ No ☐ **Liver disease?**
Yes ☐ No ☐ **Hepatitis? A☐ B☐ C☐**
Yes ☐ No ☐ **Diabetes? Type 1☐ Type 2☐ Prediabetic☐**
Yes ☐ No ☐ **Are you Pregnant? How many weeks?____**
Yes ☐ No ☐ **Taking birth control/hormones?**
Yes ☐ No ☐ **Latex allergy?**
Yes ☐ No ☐ **Local Anesthetics allergy?**
Yes ☐ No ☐ **Allergy to aspirin, acetaminophen or ibuprophen?**
Yes ☐ No ☐ **Sulfa allergy?**
Yes ☐ No ☐ **Penicillin/Antibiotic allergy?**
Yes ☐ No ☐ **Narcotic allergy?**

If you have answered yes to any of these questions, please explain? _____

Do you have any other disease, condition or problem not listed above? _____

List your current medications and/or supplements: _____

Dental Health History:

Yes ☐ No ☐ Are you apprehensive about dental treatment?

Yes ☐ No ☐ Have you had problems with previous dental treatment?

Yes ☐ No ☐ Do you gag easily?

Yes ☐ No ☐ Do you wear dentures?

Yes ☐ No ☐ Does food catch between your teeth?

Yes ☐ No ☐ Do you have difficulty chewing your food?

Yes ☐ No ☐ Do you chew on only one side of your mouth?

Yes ☐ No ☐ Do you avoid brushing any part of your mouth because of pain?

Yes ☐ No ☐ Do your gums bleed easily?

Yes ☐ No ☐ Do your gums bleed when you floss?

Yes ☐ No ☐ Do your gums feel swollen or tender?

Yes ☐ No ☐ Have you ever noticed slow-healing sores in or around your mouth?

Yes ☐ No ☐ Are your teeth sensitive?

Do you feel twinges of pain when your teeth come in contact with:

Yes ☐ No ☐ Hot foods or liquids?

Yes ☐ No ☐ Cold foods or liquids?

Yes ☐ No ☐ Sour foods?

Yes ☐ No ☐ Sweet foods?

Yes ☐ No ☐ Do you take fluoride supplements?

Yes ☐ No ☐ Are you satisfied with the appearance of your teeth?

How often do you brush? _____

How often do you floss? _____

Sleep, Snoring & Apnea History:

Yes ☐ No ☐ Do you become easily fatigued?

Yes ☐ No ☐ Do you snore or have been told you do?

Yes ☐ No ☐ Do you wake up with a headache?

Yes ☐ No ☐ Have you been told you stop breathing while asleep?

Yes ☐ No ☐ What would you rate the quality of your sleep?
☐ Good ☐ Fair ☐ Poor

Yes ☐ No ☐ Have you been diagnosed or treated for a sleep disorder?

Yes ☐ No ☐ Have any immediate family members diagnosed or treated for a sleep disorder?

Yes ☐ No ☐ Have you ever had an evaluation at a sleep center?

Yes ☐ No ☐ If you sought treatment for a sleep disorder, did it help?

TMJ History:

Yes ☐ No ☐ Do you clench or grind your jaws frequently?

Yes ☐ No ☐ Do your jaws ever feel tired?

Yes ☐ No ☐ Does it hurt when you chew or open wide to take a bite?

Yes ☐ No ☐ Do you have earaches or pain in front of the ears?

Yes ☐ No ☐ Do you have jaw symptoms or headaches upon awaking in the morning?

Yes ☐ No ☐ Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities?

Yes ☐ No ☐ Do you have a temporomandibular (jaw) disorder (TMJ)

Yes ☐ No ☐ Do you have pain in the face, cheeks, jaws, joints, throat, or temples?

Yes ☐ No ☐ Are you able to open your mouth as far as you want?

Yes ☐ No ☐ Are you aware of an uncomfortable bite?

Yes ☐ No ☐ Have you had a blow to the jaw (trauma)?

Yes ☐ No ☐ Are you a habitual gum chewer?

Yes ☐ No ☐ Are you a habitual pipe smoker?

Yes ☐ No ☐ Are you aware of your jaw popping, clicking or making noises?

Yes ☐ No ☐ Have you ever been told you grind your teeth at night?

ASSIGNMENT OF BENEFITS I understand that the information is correct to the best of my knowledge and it will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I hearby authorize my insurance benefits to be paid directly to Dr. Weigand. I understand I am financially responsible for noncovered services, as well as any remaining balance after my insurance has paid. I authorize the release of information for insurance purpose and give consent for Dr. Weigand and his staff to treat me.

_____ _____

Patient signature / legally authorized representative: *Date:*

_____ _____

Print name if signed on behalf of the patient : *Relationship:*

_____ _____

Dentist signature: *Date:*