Juno:
14050 US Hwy 1, Suite D
Juno Beach, FL 33408
561-622-7220

West Palm Beach:
1515 N Flagler Dr, Suite 360
West Palm Beach, FL 33401
561-659-1688

New Patient Information

Patient's Name _____ Date of Birth _____
How do you wish to be addressed? _____ Marital Status _____
Address _____
STREET CITY STATE ZIP
Home Phone _____ Work Phone _____
Cell Phone _____ Email _____
SS# _____ Employer _____
If patient is a minor, give parent's or guardian's name _____

How did you hear about our office? ___ Google ___ Radio ___ Friend/Family ___ Walk-In ___ Doctor
___ Social Media ___ Other: _____

Has a family member ever been to our office? Yes _____ No _____

Dental Insurance

Insurance Company _____ ID/Subscriber #_____
Group Number _____
Policy Holder Name_____ Policy Holder Date of Birth _____

Consent

The undersigned hereby authorizes Weinberg Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by my Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize my Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that my Doctor may choose and employ such assistance as he/she sees fit. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time of services rendered. I understand that in the event that I am referred to a specialist's office for additional treatment, that services rendered in that office are my financial responsibility and are separate from Weinberg Dentistry. I further understand that a 1.5% finance charge (18%) annually will be added to any balance over 60 days. In the event of default, I (we), promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney's fees as may be required to effect collection of this note.

I authorize the release of information to all my insurance carriers. I understand that I am responsible for my bill.

Patient Signature: _____ Date: _____

Patient Name (please print): _____

Medical History

1. Are you in good health? ..... [ ] Yes [ ] No
2. Has there been a change in your general health within the past year? .....[ ] Yes [ ] No
3. Do you require pre-medication prior to dental procedures? (hip and/or knee replacements, etc.) [ ] Yes [ ]No
4. Are you under the care a physician? ..... [ ] Yes [ ] No
5. If so, what condition is being treated? _____
6. Date of your last visit to your physician _____ Nature of visit _____
7. Your physician's name _____ Phone #_____
   Address of physician _____
8. Have you ever been hospitalized or had a serious operation or illness within the last five years? .... [ ] Yes [ ] No
   If so, for what? _____

9. Do you have, or have you had, any of the following diseases or problems? **Please check:**

[] Heart Failure	[] Kidney Trouble	[] Sinus Trouble	[] Nervousness/Anxiety
[] Emphysema	[] AIDS/HIV	[] Rheumatism	[] Chemotherapy (e.g. Cancer)
[] Diabetes	[] Ulcers	[] Allergies or Hives	[] Leukemia
[] Lupus	[] Cold Sores	[] Cortisone Medicine	[] Radiation Treatment (head, neck)
[] Thyroid disease	[] Bruise Easily	[] Scarlet Fever	[] Heart Disease or Attack
[] Angina Pectoris	[] Arthritis	[] Artificial Joint	[] Mitral Valve Prolapse
[] Glaucoma	[] Glaucoma	[] Anemia	[] STD or VD (e.g. Syphilis, Gonorrhea)
[] Tuberculosis (TB)	[] Hepatitis A, B, or C	[] High Blood Pressure	[] Psychiatric Treatment
[] Sickle Cell Disease	[] Pain in Jaw Joints	[] Artificial Heart Valve	[] Fainting or Dizzy Spells
[] Asthma	[] Blood Transfusion	[] Heart Pacemaker	[] Epilepsy or Seizures
[] Heart Murmur	[] Liver Disease	[] Stroke	[] Bleeding Disorder
[] Hay Fever	[] Yellow Jaundice	[] Heart Surgery	[] Rheumatic Fever
[] Jaundice	[] Stomach Problems	[] Respiratory Problems	[] Other: _____

10. Are you taking any drugs, medicines, or vitamin supplements? ..... [] Yes [] No
If so, please list_____
11. Are you allergic, or have you reacted adversely, to any drugs or medicine? ..... [] Yes [] No
    If so, which: [] Aspirin [] Erythromycin [] Codeine [] Local Anesthetic [] Epinephrine [] Latex
    [] Penicillin [] Nitrous Oxide [] Novocain or Xylocaine [] Other: _____
12. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest? [] Yes [] No
13. Do your ankles swell during the day? ..... [] Yes [] No
14. Do you have a disease condition, or problem not listed above that you think I should know? ..... [] Yes [] No
15. For women only: Are you pregnant?..... [] Yes [] No If so, what month? _____
    Breast-feeding? ..... [] Yes [] No
    Are you taking birth control pills?..... [] Yes [] No

Patient Signature: _____ Date: _____

Patient Name (please print): _____

Dental History Date of your Last Cleaning: _____

Please Handle Me with Care

Please check any of the following statements that concern you or describe your situation

- ☐ I have not been to the dentist in a long time and I feel worried about what you will say about my teeth and my oral hygiene.
- ☐ My teeth are very sensitive.
- ☐ Pain relief is a top priority for me.
- ☐ I'm very anxious about injections.
- ☐ I feel out of control in the dental chair (or I have an extreme problem with lying down).
- ☐ I gag easily.
- ☐ I hate the noise of dental instruments.
- ☐ I hate the sight and/or smell of a dental office.
- ☐ Please tell me about the treatment options and the ways these can be carried out.
- ☐ I need to know that you will stop when I give a pre-agreed "stop" signal during treatment.
- ☐ It would help me if you could explain to me what you are doing and why.
- ☐ I have medical problems that we need to discuss.
- ☐ There are other issues I'd like to talk about that aren't covered on this form: _____
  _____
  _____

- ☐ What special things can we do in our office to make sure you are well cared for?: _____
  _____
  _____

Please check any of the following that apply to you:

□ Sensitivity
□ Loose, tipped, or shifting teeth
□ Teeth or fillings breaking
□ Bad breath
□ Headaches, earaches, neck or jaw joint pain
□ Grinding or clenching
□ Mouth Ulcers or Cold Sores
□ Bleeding, swollen or irritated gums

If I could change my smile, I would:

□ Make my teeth whiter
□ Replace missing teeth
□ Replace metal fillings with tooth colored fillings
□ Replace old crowns that don't match
□ Have a smile makeover
□ Make my teeth straighter
□ Nothing, I am happy with my smile
□ Close spaces / gaps

Do you have or have you had any of the following?

□ Braces □ Partial/Dentures □ Periodontal Gum Treatment

On a scale of 1-10, with 10 being the highest rating: Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where would you like to be?

1 2 3 4 5 6 7 8 9 10

Cancellation and Missed Appointment Policy

Weinberg Dentistry only sees one patient at a time to give each patient their full attention and he only sees a limited number of patients per day. We reserve a specific block of time for each patient and that scheduled appointment is reserved for your exclusive use.

We also meticulously prepare for each appointment by reviewing your paperwork and treatment plan prior to your appointment to help provide you with the best care possible. In order to provide you with the best possible service, we expect you to be present and on time to each of your scheduled appointments. For these reasons, if you are not able to make your appointment as scheduled, we need to know 48 hours in advance so that we can contact other patients in need who are waiting for an appointment.

We have a **48-hour (2 business days) cancellation policy**.

Two days prior to your appointment you will receive notifications regarding the time and date of your next visit. If you are unable to keep your appointment as scheduled, please let us know **48-hours** (2 business days) in advance in order to avoid a broken appointment charge. We request that you speak to our office directly; we do not accept voicemails or emails as form of cancellation. If you have a 9:00 am Monday appointment, we need to hear from you by 9:00 am on the Thursday before your appointment.

If we do not hear from you two or more business days prior to your appointment, you will be charged a broken appointment fee of 50% of the appointments scheduled services with the doctor. All broken appointments with the hygienist will be charged a $60 fee.

Please keep our policy in mind when scheduling appointments. Our entire team is focused on making this the best experience possible. If you have any questions or concerns, please feel free to speak to any member of our team.

Patient Signature: _____ Date: _____

Patient Name (please print): _____

To Our Patients

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, fast and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely in your file. This is an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out.

Any amount owed for services rendered at the time of your visit will be due at check-out. If you wish to use a different form of payment for that visit when checking out in our office, please let us know.

Once services have been permanently completed, no refunds can be issued.

Patient Signature: _____ Date: _____

Speedy Check-Out

I authorize Weinberg Dentistry to charge outstanding balances on my account to the following credit card:

Please circle one: VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Account number _____ Exp. date_____ CVV _____

Name on card (please print) _____

Billing Address: _____

Patient Signature _____ Date_____

HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights Section describing your right under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change your notice, you may obtain a revised copy by contacting our office, or going to our website. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment or health care operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment or health care operations.
2. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
3. The Practice reserves the right to change the Notice of Privacy Policies.
4. The Patient has the right to restrict the uses of their information.
5. The Patient may revoke this consent in writing at any time and all future disclosure will then cease.
6. The Practice may condition treatment upon execution of this consent. No insurance can be billed on the patient's behalf without this signed HIPAA Consent form, therefore same day of service payment in full for any services will be required.

This HIPAA Consent was signed by: _____ Date: _____

(Print Name)

Signature of Patient or Guardian: _____