Laser & Cosmetic Dental Center of Boca Raton
Dr. Gregg Weinstein DDS

500 NE Spanish River Blvd, Suite 34 • Boca Raton, FL 33431

Patient Information

Patient Name: _____ Date: *12/05/2023*
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cellular: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Height: _____ Weight: _____ Occupation: _____ Email: _____

Closest Relative: _____ Phone Number: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Who referred you to our practice? _____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____

- Name of Physician: _____ Phone: _____
  Address: _____

- **Do you have or have you had any of the following diseases or problems: ☐ Yes ☐ No**
  Please check those that apply.

☐ **Heart Murmur**
☐ Arrhythmia
☐ Ateriosclerosis
☐ Cardiovascular disease
☐ Coronary insufficience

☐ **Rheumatic Fever or Rheumatic Heart Disease**
☐ Coronary occlusion
☐ Heart attack
☐ Heart trouble

☐ **Congenital Heart Lesions**
☐ Prolapsed or replaced heart valve
☐ Stroke

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies
_____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Congenital Heart Lesions
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths

☐ Hay Fever
☐ Head Injuries
☐ Heart Attack
☐ Heart Disease

☐ Hepatitis
☐ High Blood Pressure
☐ Hives or skin rash
☐ Inflammatory Rheumatism
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker

☐ Prosthetic Hip or other joint

☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Heart Disease
☐ Rheumatic Fever
☐ Rheumatism
☐ Seizures
☐ Sinus Problems
☐ Stomach Problems

☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

Are you allergic to:
☐ Aspirin
☐ Barbiturates
☐ Codeine
☐ Latex Allergy
☐ Local Anesthetic (Novocain)
☐ Iodine
☐ Penicillin
☐ Sedatives or Sleeping Pills

OTHER:
☐ _____
☐ _____

Women: Are you pregnant? ☐ Yes ☐ No

Do you have any problems associated with your menstrual period? ☐ Yes ☐ No

- **Please list all current medications and please check all those apply:**

☐ Antibiotics or Sulfa Drugs
☐ Anticoagulants (blood thinners)
☐ Medicine for high blood pressure
☐ Cortisone (steroids)
☐ Tranquilizers
☐ Other, Please list all medications (prescribe or non prescribed)_____
_____
_____

☐ Aspirin
☐ Insulin, Tolbutamide (orinase or similar drug)
☐ Digitalis or drugs for heart trouble
☐ Nitroglycerine
☐ Antihistamines

- Do you have pain in the chest upon exertion? ☐ **Yes** ☐ **No**
- Are you ever short of breath after mild exercise? ☐ **Yes** ☐ **No**
- Do your ankles swell**?** ☐ **Yes** ☐ **No**
- Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ☐ **Yes** ☐ **No**
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ **Yes** ☐ **No**
  If yes, please explain:_____
- Do you take vitamins or dietary supplements? ☐ **Yes** ☐ **No**
- Have you ever had any complications following dental treatment? ☐ **Yes** ☐ **No**
  If yes, please explain:_____
- Have you ever had complications with anesthesia or sedation**?** ☐ **Yes** ☐ **No**
- Do you have a persistent cough or cough up blood? ☐ **Yes** ☐ **No**☐
- Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ☐ **Yes** ☐ **No**
- Do you bruise easily? ☐ **Yes** ☐ **No**
- Have you ever required a blood transfusion? ☐ **Yes** ☐ **No**
- Have you had surgery or X-ray treatment for a tumor, growth or other condition of your mouth or lips? ☐ **Yes** ☐ **No**
- Do you have any health problems that need further clarification? ☐ **Yes** ☐ **No**
  If yes, please explain:_____
- **Are you taking or have you ever taken any medications for Osteoporosis**? ☐ **Yes** ☐ **NO**
  If yes please circle: Actonel, Aredia, Boniva, Boneios Ostec, Didronel, Fosamax, Skelid, Zometa

I certify that I speak, read and write English and have read and fully understand this consent for dental work, have had my questions answered and that all blanks were filled prior to my initials or signature.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date**: _____ **Signature of Dentist:** _____
Signature of patient, parent or guardian

For Minors Only: I hereby give consent to Dr. Weinstein and staff to perform x-rays, prophylaxis (cleaning), fluoride treatment, operative dentistry and anesthetics (by Dr. Weinstein). Sign below for your consent.

Signed_____ Date_____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other Name of person or office referring you to our practice: _____ **Please ask us about our patient referral program!**

Primary Insurance Information

Name of Insured: _____ Is the insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Acknowledgment of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

The undersigned acknowledges disclosure of the currently effective Notice of Privacy Practices for Gregg Weinstein., DDS., this _____day of _____, _____. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____
PLEASE PRINT YOUR NAME

_____
PLEASE SIGN YOUR NAME

If you are the legal representative of the patient, please print the patient's name and describe your authority:_____.

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer.

Office Use Only: As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

____ It was emergency treatment.
____ I could not communicate with the patient.
____ The patient refused to sign.
____ The patient was unable to sign because_____
____ Other (please describe): _____

Signature of privacy officer: _____

Patient Financial Responsibility

If you cannot keep an appointment, our office asks that you give us a **48** hour notice. Your appointment time is reserved just for you and the doctor and a short notice of cancellation or a "No show", is a loss to our other patients who desire to see the doctor. For a "no show" or broken appointment, a charge will be applied of $100.00 for those who do not inform us of cancellation.

Signed_____ Date_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge 1.5% per month (18% annually) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
I understand that the gee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to be, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, a t the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time of payment thereof. I further agree that a waiver of any breach of anytime or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian	Date	Relationship to patient
Signature of guarantor of payment Or Responsible party	Date	Relationship to patient

Acceptance of Uncovered Insurance Charges

I, the undersigned, understand that although I have assigned insurance benefits to this office it is likely and probable that my insurance coverage will be less than the amount billed and paid by the insurance company. I acknowledge that it is probable that my insurance may or may not pay for charges incurred in this office. I am responsible for any charges refused or discounted by my insurance, once insurance benefits have been paid. Further, it is my responsibility to pay for any collection/legal fees, if incurred in the collection of these uncovered charges should I fail to pay them during the agreed time.

Signed_____ Date_____

BOCA DENTAL

GREGG WEINSTEIN DDS & ASSOCIATES

Patient Photo Release Form

I hereby authorize Boca Dental to take photos, slides, and/or videos of my face, head, and neck areas, including the profile, face, teeth, smile, and intraoral features.

I understand that the photos, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (company website, newspapers, magazines, and social media, including Facebook, Instagram, Twitter, and Google+), and professional publications (dental magazines and journals).

I hereby waive any right that I might have to inspect or approve the finished product(s) or advertising copy to which the photos, slides, and/or videos may be applied.

I further understand that if the photos, slides, and/or videos are used in any publication or as a part of a demonstration, my name (First Name Only) or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

Please initial:
_____I do not mind if my first name, face, and teeth are used in any of the above stated situations. Exceptions:
_____I do not wish to have my First Name shown, or released.
_____I do not wish to have my face shown.
_____I only agree to have my teeth shown without any identifying features.
_____I do not wish to have my photos used at all.

Patient's Name (print): _____Date: _____

Signature: _____

Guardian (if under legal age): _____

Guardian Signature: _____

Provider (print): _____

Provider Signature: _____