

Brion S. Weinberg, D.D.S.,F.A.G.D.
14050 US 1, Suite D
Juno Beach, FL 33408
561-622-7220

WELCOME

Dr. Brion S. Weinberg and his staff would like to welcome you to the office. We want to thank you for choosing us to care for your dental needs. Our goal is for you to attain optimal oral health and to maintain a beautiful healthy smile. We are committed to our patients, and to their need to find a dentist who can help them to reach their goals and achieve their expectations in the most experienced and professional manner.

Dr. Weinberg is a unique type of dentist. His extensive knowledge of comprehensive dentistry and use of state-of-the-art technology is combined with a gentle style and an intense focus on aesthetics. He has completed extensive post-doctoral studies in cosmetic and restorative dentistry, including how to create a natural looking smile. He has done continuing education at the Pankey Institute for Advanced Dental Education and he has recently received his Fellowship Award from the Academy of General Dentistry. Even though he has an exceptional focus on the clinical dentistry, Dr. Weinberg takes the time to get to know each patient on a one-on-one basis, and focuses on their own personal needs and expectations.

Dr. Weinberg and his team welcome the opportunity to take care of the dental needs of you and your family members. We thank you for your trust in us and we look forward to meeting you and helping you to attain optimal oral health.

Your optical needs can also be taken care of by Dr. Cici Weinberg at Juno Beach Optical, which is co-joined with our office.

Patient's Name _____

DENTAL HISTORY

- 1. Are you aware of any dental problems at this time? Yes No
2. When was your last dental visit? What was performed? Last X-ray's and Exam date
3. Have you had a dental cleaning within the last year? Yes No
4. Have you had any of the following treatment? Orthodontics, Endodontics (Root Canal), Periodontics (Gum Therapy)? Yes No
5. Do you experience pain or clicking in your jaw, ear, or facial muscles upon opening your mouth? Yes No
6. Have you ever had instructions in oral hygiene technique? Yes No
7. How often do you brush your teeth? Yes No
8. Do your gums bleed? Yes No
9. Are you aware of grinding or clenching your teeth? Yes No
10. Do you suffer anxiety or gagging during dental procedures? Yes No
11. How are your teeth important to you? Yes No
12. Do you want to avoid dentures? Why? Yes No
13. Are you unhappy with the appearance of your teeth? Why? Yes No
14. What changes would you make?
15. Interests and hobbies?
16. Do you smoke or use tobacco? Yes No

MEDICAL HISTORY

- Are you under a physician's care now? Who? Why? Yes No
Have you ever been hospitalized or had a major operation? Discuss Yes No
Have you ever had a serious injury to your head or neck? Discuss Yes No
Are you taking any medications, pills or drugs? What? Yes No
Are you on a special diet? Discuss Yes No
Are you allergic to any medications or substances? Please check box below Yes No
Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other
WOMEN (Please check): Pregnant/trying to get pregnant Nursing Taking contraceptives Discuss Yes No

*If yes to any of the starred conditions, please call prior to your appointment.....Premedication may be required.

Table with 4 columns of conditions and Yes/No checkboxes. Conditions include Heart Trouble/Diseases, Bruise Easily, Emphysema, Yellow Jaundice, Cod Sores, etc.

- Have you ever had any other serious illness not checked above? Discuss Yes No
Do you wish to talk to the dentist privately about any problem? Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X PATIENT SIGNATURE (PARENT OR GUARDIAN) Date

Reviewed by doctor Date BP

History Review and Significant Findings:

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated and confirm that it adequately states past and present conditions.

Table with 4 columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, REVIEWED BY. Includes checkboxes for None.

BRION S. WEINBERG, DDS
CENTER FOR AESTHETIC AND RESTORATIVE DENTISTRY

CONSENT FOR TREATMENT

1. I HEREBY AUTHORIZE DOCTOR OR DESIGNATED STAFF TO TAKE XRAYS, STUDY MODELS, PHOTOGRAPHS, AND ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DOCTOR TO MAKE THOROUGH DIAGNOSIS OF _____'S DENTAL NEEDS.

2. UPON SUCH DIAGNOSIS I AUTHORIZE THE DOCTOR TO PERFORM ALL RECOMMENDED TREATMENT MUTUALLY AGREED UPON BY ME AND EMPLOY SUCH ASSISTANCE AS REQUIRED TO PROVIDE PROPER CARE.

3. I AGREE TO THE USE OF ANESTHETICS, SEDATIVES, AND OTHER MEDICATION AS NECESSARY. I FULLY UNDERSTAND THAT USING ANESTHETIC AGENTS EMBODIES CERTAIN RISKS. I UNDERSTAND THAT I CAN ASK FOR A RECITAL OF ANY POSSIBLE COMPLICATIONS.

4. LASTLY, I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDANTS. I UNDERSTAND THAT PAYMENTS ARE DUE AT TIME OF SERVICE. UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. IN THE EVENT PAYMENTS ARE NOT RECEIVED BY AGREED UPON DATES, I UNDERSTAND THAT A 1-2% LATE CHARGE (18% APR) MAY BE ADDED TO MY ACCOUNT.

PATIENT _____ DATE _____

WITNESS _____ DATE _____

PARENT/PARTY RESPONSIBLE _____

RELATIONSHIP TO PATIENT _____

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE				1
NAME				
SPOUSE				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
DATE				
NAME				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO				

1
IF THIS APPOINTMENT IS FOR YOU START HERE

1
IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

2

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		

3

ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	

4

GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP	
REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

I will be paying today by Cash Check Credit Card

FEES AND PAYMENTS: Payment is expected upon completion of each visit. Other arrangements can be made with our Office Manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you before treatment. If you have any dental insurance we will be glad to fill out the proper forms but please complete the identifying information at the top of the form. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company.