

# Dana A. Weinreich, D.D.S.

## FAMILY & COSMETIC DENTISTRY

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### PATIENT HISTORY AND INFORMATION

The following information, which is confidential, is requested by the Doctor to give you personal attention and a thorough diagnosis.  
Please complete all 3 pages.

Patient's name \_\_\_\_\_ Mr., Mrs, Ms., Miss, Dr., Rev.  
(circle one)  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zipcode \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_  
Email Address \_\_\_\_\_  
Do we have permission to leave message at home #? Y \_\_\_ N \_\_\_ Call work Y \_\_\_ N \_\_\_ Call Cell? Y \_\_\_ N \_\_\_  
Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ Soc. Sec.No. \_\_\_\_\_  
Your Employer \_\_\_\_\_ Dental Insurance Co. \_\_\_\_\_  
Responsible Party \_\_\_\_\_ DOB \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
Spouse (Parent's) Name \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

### MEDICAL HISTORY

Physician's name \_\_\_\_\_ Last physical exam? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Are you under Medical Treatment now? \_\_\_\_\_ Why? \_\_\_\_\_  
Are you taking any Medication now? \_\_\_\_\_ What kind? \_\_\_\_\_  
Are you sensitive to any Medications? \_\_\_\_\_ Which ones? \_\_\_\_\_  
Do you have any Allergies? \_\_\_\_\_ What kind? \_\_\_\_\_  
Have you ever had: Rheumatic Fever Liver Disease(Hepatitis) Heart Problems  
Diabetes Psychiatric Treatment Cancer/Tumor  
Epilepsy Asthma Sinus problems  
Do you smoke? High Blood Pressure Anemia  
Latex Allergy Lung Disease/T.B. Kidney Disease  
Excessive Bleeding Are you pregnant?(women)  
Hip, Knee, Joint Replacement  
Tested for H.I.V.(AIDS) Results positive  negative   
Are there any other Medical conditions we should be aware of? \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

(Please continue to next page)

*We reserve the right to charge for missed appointments*