Brad Weiss D.D.S., LTD

Patient Information

Date_____

Name: Last_____

First_____

Home Address_____

City_____ State_____ Zip_____

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____E-mail_____

Which method of communication would you like us to use to be confirmed? Phone___Email___Text___

Date of Birth_____ Sex_____

Occupation_____ Social Security #_____

Marital Status….Single _____ Married _____ Widowed_____Divorced_____

Referred by_____

In case of emergency, whom may we call? _____

Reason for today's visit_____

Account Information

Do you have dental insurance? NO_____YES_____ If yes, please complete the details below:

Insurance Carrier: _____

Name of the Primary Insurance Subscriber:_____

Relationship to patient_____ Date of Birth:_____

Member ID # (or SSN) _____ Group #_____

Employer_____ Carrier Phone #_____

Whom is responsible for account payment? _____

Consent

- **The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a through diagnosis of the patient's dental or oral facial needs including x- rays, medications and the use of local anesthetics.**
- **The undersigned hereby certifies that all information given is complete and accurate.**
- **The undersigned hereby agrees to pay all costs of collection and reasonable attorney fees, should it become necessary to refer your account to an attorney for collection.**

_____ _____

Patient or Guardian Signature Date

Name of person signing if other than patient _____

WEISS DENTAL ARTS

Medical History Form

Patient's Name: _____ Date: ____ /____ /____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes
Have you ever been hospitalized or had a major operation?	Yes	No	If yes
Have you ever had a serious head or neck injury?	Yes	No	If yes
Are you taking any medications, pills or drugs?	Yes	No	If yes
Did you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphophonates?	Yes	No	If yes
Are you on a special diet?	Yes	No	If yes
Do you use tobacco?	Yes	No	If yes

Women: Are you...

Pregnant/Trying to get pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Local Anesthetics
- Metal
- Latex
- Sulfa Drugs
- Other? If yes

Do you use controlled substances?

Yes No If yes

Please check any of the following conditions that apply to you:

- AIDS/HIV Positive
- Alzeimer's Disease
- Anaphylaxis
- Anemia
- Angina
- Arthritis/Gout
- Artificial Heart Valve
- Artificial Joint
- Asthma
- Blood Disease
- Blood Transfusion
- Breathing Problems
- Bruise Easily
- Cancer
- Chemotherapy
- Chest Pain
- Cold Sores/Fever Blisters
- Congenital Heart Disorder
- Convulsions
- Cortisone Medication
- Diabetes
- Drug Addiction
- Easily Winded
- Emphysema
- Epilepsy or Seizures
- Excessive Bleeding
- Excessive Thirst
- Fainting Spells/Dizziness
- Frequent Cough
- Frequent Diarrhea
- Frequent Headaches
- Glaucoma
- Hay Fever
- Heart Attach/Failure
- Heart Murmur
- Heart Pacemaker
- Heart Trouble/Disease
- Hemophilia
- Hepatitis A
- Hepatitis B or C
- Herpes/Cold Sores
- High Blood Pressure
- High Cholesterol
- Hives or Rash
- Hypoglocemia
- Irregular Heartbeat
- Kidney Problems
- Leukemia
- Liver Disease
- Low Blood Pressure
- Lung Disease
- Mitral Valve Prolapse
- Osteoporosis
- Pain in Jaw Joints
- Parathyroid Disease
- Psychiatric Care
- Radiation Treatments
- Recent Weight Loss
- Renal Dialysis
- Rheumatic Fever
- Rheumatism
- Scarlet Fever
- Shingles
- Sickle Cell Disease
- Sinus Trouble
- Spina Bifida
- Stomach/Intestinal Disease
- Stroke
- Swelling of Limbs
- Thyroid Disease
- Tonsilitis
- Tuberculosis
- Tumors or Growths
- Ulcers
- Yellow Jaundice

Have you ever had any serious illness not listed? Yes No If yes

Comments:

Consent: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature *(parent if minor)* Date

Request for the Transfer of Patient Records

Please transfer my sleep study medical records, dental records, radiographs, photos, lab cases and models to the following dental office:

Weiss Dental Arts
Dr. Brad Weiss D.D.S.
Dr. Alexandra Fulreader D.D.S.
9555 Gross Point Road
Skokie, Illinois 60076
Phone: 847-864-0188
Fax: 847-475-8511
Email: office@bradweissdds.com

I authorize Weiss Dental Arts and any of its employees to receive electronically or in person any of my sleep study medical records, dental records, radiographs, photos, lab cases and models. Thank you for your assistance with this request.

Release Request Date: _____

Patient's Printed Name: _____

Patient's Signature: _____

Relationship to Patient (if not self): _____

Patient Contact # for Any Questions: _____

For office use only:

Release request sent to: _____

Request date: _____ Method of request: _____

Date and method records were received: _____

EPWORTH SLEEPINESS SCALE (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off or fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never *doze or fall asleep* in a given situation, and 3 meaning there is a very high chance that you would *doze or fall asleep* in that situation.

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you circle a number (0 to 3) for EACH situation.

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (theater/meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

TOTAL SCORE _____

Name: _____

Date: _____

Revised 09/25/08