Weninger Dentistry, P.L.L.C.

www.WeningerDentistry.com
Smile@WeningerDentistry.com
4030 North MacDill Avenue • Tampa, FL 33607
(813)872-7057

Information Update

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* (Last) _____* (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:*** ☐ Male ☐ Female **Family Status:*** ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date:* _____ **Email Address:** _____

Phone: _____* (Home) _____* (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____* (Address 1) _____ (Address 2)

_____* (City) _____* (State) _____-_____* (Zip Code)

Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ___ (MI)

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

Insurance Plan Name: _____

Insurance phone number _____

Policy Holder's Date of Birth: _____

Insured/Subscriber ID# _____

Group # _____

Policy Holder's Zip Code _____

Permissions

Telephone, Mail, Email and/or Text Messages:

I grant my permission to Weninger Dentistry or its assignee(s), to contact me (including leaving messages on voice mail, emailing, mailing, texting or with any individual(s) on my HIPAA) related to any of my dental records, dental treatment, account balance, account collection matters, dental appointments, or any other dental matter.*

☐ Yes ☐ No

NO SHOW/LATE CANCELLATION FEES

Our goal is to provide quality health care to all our patients in a timely manner.

No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well.
When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients.
Appointments are in high demand, and your advanced notice if you will not be able to keep your scheduled appointment, will allow another patient access to that appointment time.

If cancellation is necessary, we ask that you please contact us at least 48 hours (2 business days) in advance of your scheduled appointment date by: calling (813) 872-7057 or texting (813) 344-3386.

My signature below represents I understand the importance of notifying my dentist at least 48 hours prior to my scheduled appointment if I am not able to keep my appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid being charged the Cancellation fee of $45. I also understand I will be charged a No-Show fee of $45 for failing to call or show for my scheduled appointment.

I have read and do understand the contents of this form and with my signature below, I will need to pay the broken appointment fee at the time of rescheduling my appointment if I miss an appointment or cancel with less than two business days notice.

☐ * **By checking this box, I acknowledge that I have read this statement and agree to the contents.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand at any time, this authorization may be revoked, when the office receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I authorize Weninger Dentistry to release ANY and ALL dental information to the following person(s). I also understand that Weninger Dentistry will not be held responsible for verifying identification on the individual(s) listed below.

HIPAA : List name(s) and relationship. If no one, please enter "None." *

_____

_____

_____

_____

Medical Update

Name and phone number of your physician:

_____

_____

☐ * **Indicate which of the following conditions are active or current.**
By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ Alcohol Use	☐ Allergy Amoxicillin	☐ Allergy Aspirin	☐ Allergy Augmentin
☐ Allergy Cipro	☐ Allergy Clindamycin	☐ Allergy Codeine	☐ Allergy Darvon
☐ Allergy Keflex	☐ Allergy Latex	☐ Allergy Penicillin	☐ Allergy Sulfa
☐ AllergyErythromycin	☐ AllergyTetracycline	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Bisphosphonates	☐ Blood Disease
☐ Blood Thinners	☐ Carbonated Beverages	☐ Chewing Gum	☐ Circulatory Problems
☐ Diabetes	☐ Dizziness	☐ EPI Sensitivity	☐ Earaches
☐ Eating Candies	☐ Epilepsy	☐ Excessive Bleeding	☐ FEMALE: BC Pills
☐ FEMALE: Nursing	☐ FEMALE: Pregnant	☐ Facial Pain	☐ Glaucoma
☐ HIV	☐ Head Injuries	☐ Headaches	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ Hypothyroidism
☐ Kidney Disease	☐ Low Blood Pressure	☐ Mitral Valve Prolapse	☐ Nervous Disorders
☐ Other	☐ Pacemaker	☐ Pre-med	☐ Radiation Treatment
☐ Recent Hospitalized	☐ Respiratory Disease	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Ringing in ears	☐ Sleep Apnea	☐ Stroke
☐ Sucking Fruits	☐ Tobacco/Vaping	☐ Tuberculosis	☐ Use Insulin

If any conditions or alerts selected above need further clarification, please describe:

_____

_____

Have you ever been instructed to take antibiotic premedication for your dental visits? If yes, please explain: *
☐ Yes ☐ No

Pre med:

_____

_____

Describe any current medical treatment or impending surgery.

_____

_____

Are you currently taking or have you ever taken bone density medication (Bisphosphonates) such as Boniva, Fosamax, Didronel, Zometa, Actonel, etc? If yes, please describe below
☐ Yes ☐ No

Bisphosphonate:

_____

_____

MEDICATIONS (prescription and non-prescription) including regular doses of aspirin. If no medications, please type "None." *

DRUG ALLERGIES If no allergies, please type "None." *

Pharmacy

Name:

Phone Number:

Street Address:

Provider notes:

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Name of patient, parent or guardian completing this form: *

Signature **Date**

Response Date: