Howe Dental Associates
Dr. Michael Weiner, D.D.S.
15 Howe Ave, Suite 2B, Passaic, NJ 07055
NPI: 1356648422 — NJ License: 22DI02459000
Tel: 973.365.1931 — Fax: 973-365-1590

Email: HoweDentalAssociates@gmail.com Web: www.howedentalnj.com

Date: _____ Referred by: _____

Patient information

Patient

Patient's name: _____ DOB: _____

If minor: parent's name: _____ Male / Female

SSN: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____

Email address: _____

Home/Cell #: _____ Work #: _____

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced

Emergency Contact: _____ Relation: _____ Tel: _____

Primary Dental Insurance

Insurance Company Name: _____

Group name: _____ Group #: _____

Subscribers name: _____ DOB: _____

Relationship to patient: _____

Secondary Dental Insurance

Insurance Company Name: _____

Group name: _____ Group #: _____

Subscribers name: _____ DOB: _____

Relationship to patient: _____

Primary Medical Insurance

Insurance Company Name: _____

Group name: _____ Group #: _____

Subscribers name: _____ DOB: _____

Relationship to patient: _____

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Medical Health History

Do you have or have you had any of the following?
(Please check any that apply)

__ Cancer or Tumor
__ Heart ailment or angina
__ Heart murmur, mitral valve prolapse, Heart defect
__ Rheumatic fever or rheumatic heart disease
__ Artificial joint or valve
__ High / Low blood pressure
__ Pacemaker
__ Tuberculosis or other lung problems
__ Kidney Disease
__ Hepatitis or other liver disease
__ Alcoholism
__ Blood Transfusion
__ Diabetes
__ Neurologic condition
__ Epilepsy, Seizures, or fainting spells
__ Emotional Condition
__ Arthritis
__ Herpes and/or cold sores
__ AIDS or HIV+
__ Migraines or frequent headaches
__ Anemia or blood disorders
__ Abnormal bleeding after extractions, Surgery, or trauma
__ Hay-fever or sinus troubles
__ Allergies or Hives
__ Asthma

Do you smoke? Or use chewing tobacco? Yes / No

Are you allergic to, or have you reacted adversely to any of the following?

__ Latex Materials
__ Penicillin or other antibiotics
__ Local anesthetics (Novocain)
__ Codeine or other narcotics
__ Sulfa Drugs
__ Barbiturates, Sedatives, or Sleeping Pills
__ Aspirin
__ Other: _____

Are you taking any of the following?

__ Aspirin
__ Anticoagulants
__ Antibiotic or Sulfa Drug
__ High/Low Blood Pressure Medication
__ Antidepressants or Tranquilizers
__ Insulin, Orinase, and/or other Diabetic Medication
__ Nitroglycerin
__ Cortisone or other steroids
__ Osteoporosis (bone density)
__ Other: _____

Woman:
__ Pregnant
Expected Delivery Date: _____
__ Taking hormones or contraceptives

Name of your physician: _____
Do you have any disease, condition, or problem not listed above? Yes / No
If YES, please explain: _____

Patient's signature: _____ Date: _____