Weinstein Dental Group, PLLC

MEDICAL HISTORY RECORD

Today's Date _____ Dentist Name _____ Physician Name _____

Patient Information

Name _____ (Last / First / M I) S.S.#: _____

Email: _____ Date of Birth: _____

Address: _____ (Number and Street) Home Phone. _____

_____ (City / State / Zip) Cell Phone _____

Employer: _____ Work Phone _____

Marital Status _____ Spouse/ Partner Name: _____

Person Responsible for Payment

☐ *Same as above (If so, leave this section blank)*

Name. _____ (Last / First / M I) S.S.# _____

Email: _____ Date of Birth: _____

Address: _____ (Number and Street) Home Phone: _____

_____ (City / State / Zip) Cell Phone: _____

Employer _____ Work Phone: _____

Relationship to Patient: _____

Dental Insurance

	Primary Dental Insurance	Secondary Dental Insurance (if applicable)
Insured Name.	_____ (Last / First / M I)	_____ (Last / First / M I)
Insured Birthdate	_____	_____
Employer:	_____	_____
Group # / ID #:	_____ / _____ (Group # / ID #)	_____ / _____ (Group # / ID #)
Insurance Name	_____	_____
Insurance Address	_____	_____