Patient Information

Patient Name: _____ Date:_____
Last First MI

How would you prefer our staff to address you?_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Email:_____

Daytime Number:_____ Cellular:_____ Fax:_____

Address:_____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Thyroid Disorder
☐ Latex Sensitivity
☐ Other:
_____
_____

Are you allergic to or have you had a reaction to:

- Local anesthetics __
- Aspirin ____
- Codeine, valium or other sedatives? __
- Are you taking Tagamet? (Cimetidine) ___
- Do you take Antacids? ___

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____

Are you taking any medication?_____ If so, what?_____

- Have you ever needed to take antibiotic prior to dental treatment?_____
  If yes, please explain:_____

Oral Health History

When was your last dental exam? Were x-rays taken?_____

How often do you have your teeth professionally cleaned?_____When was the last time?_____

Name and address of former dentist(if any)_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Orthodontic treatment? Periodontal treatment? Endodontic treatment? _____
Please specify_____

Are your teeth sensitive to cold, hot, sweets or pressure?(specify)_____

Does your bite feel uncomfortable?_____

Do you avoid part of your mouth while eating, chewing or biting?(specify)
_____

Do your gums bleed? If so, for how long have you had this?_____

Have you ever had acute or painful gum infections, swelling, tenderness or irritation of the gum tissue?
_____

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE OR HAD:

bad breath_____
burning of tongue_____
clenching or grinding of teeth_____
food impaction_____
frequent blisters, canker sores, or cold sores on lips or mouth_____
history of TMJ-pain or clicking jaw_____
oral habits, ie. Fingernail biting_____
pain or ringing in ear while chewing_____
swelling or lumps in mouth, on lips_____
unpleasant taste in mouth_____
How often do you BRUSH?_____ FLOSS?_____
What kind of toothbrush and dentrifice do you use?_____
Do you use a waterjet device?_____
Do you use fluoride supplements?_____

NUTRITION

Do you eat well balanced meals?_____

Do you eat in between meal snacks?_____

Do you eat red meat? How often?_____

Do you eat sugar on a daily basis? Candy? Gum? Soda?_____

Do you drink coffee or tea? How much daily?_____

Do you smoke cigarettes, pipes, or cigars? How much daily?_____

Are you satisfied with the appearance of your smile?_____

Please let us know how we can help you be satisfied with your mouth and achieve a sense of
oral well being?_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ L.I./N.Y. Naturally ☐ Creations ☐L.I. Voices
☐ Pennysaver ☐ Nursery School ☐ North Shore Woman's Paper ☐ Radio ☐ Other_____

Name of person or office referring you to our practice:_____
May we have your permission to thank the person who referred you? _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

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

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

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

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party