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(212)682-2965

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: ____________ **SS#:** ___-__-____ **Prev. Visit:** ____________

Email Address: ______________________ **Best time to call:** ____________

Phone: ________ ________ ________ ____ ________ ________
Home Mobile Work Ext Fax Other

Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Employer Name:

____

____

Primary Dental Insurance

Name of Insured: ______________ ______________ ___
Last First MI

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

Insurance Plan Name: ______________________________

Secondary Dental Insurance

Name of Insured: ______________ ______________ ___
Last First MI

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

Insurance Plan Name: ______________________________

Medical Infomation

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Other
- ☐ AIDS
- ☐ Allergies
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Ibuprofen
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Allergy- Levaquin
- ☐ Allergy- Lidocaine
- ☐ Allergy- Omnicef
- ☐ Allergy- Omnicef
- ☐ Allergy- Percocet
- ☐ Allergy-Amoxicillin
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Coumadin
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ MVP
- ☐ Neck Problems
- ☐ Nervous Disorders
- ☐ No Epi
- ☐ Other
- ☐ Pacemaker
- ☐ penicillin allergy
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Do you take antibiotic premedication for your dental visits? If yes, please explain.

____

____

If there have been any medical changes since your last visit with us, please list below.

____

____

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

____

____

Credit Care In File Form

We are committed to meeting your dental care needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. The card on file will not be charged without you being notified first.

CARDHOLDER INFORMATION

First Name * ________________________

Last Name * ________________________

Billing Address *

____

____

City * ________________________

State * ________________________

Postal Code * ________________________

Direct Number * ________________________

CREDIT CARD INFORMATION

Credit Card Type *

○ MasterCard ○ Visa ○ American Express ○ Discover Card

Number *

____

____

Expiration Month * ________________________

Expiration Year * ________________________

Security Code * ________________________

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the credit card authorization form.**

☐ ***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. This will serve as my electronic signature.**

Response Date: ____/____/________