PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____ Driver's license #: _____ State: _____

SS #: _____ Employer/Occupation: _____ Bus. Phone: _____

Spouse's name & phone #: _____ Emergency phone # (other than spouse): _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	Yes	No
How often do you brush?		
How often do you floss?		
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by physician	☐	☐
Cancer/Tumor	☐	☐

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? _____		
Do you smoke?	☐	☐
If so, how much? _____		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: _____

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

	Yes	No
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other _____		

Notes: _____

_____

_____ Date: _____

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐
Other _____		

_____

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: _____		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms? _____		

_____

Notes: _____

_____

Patient/Parent Signature: _____

Dentist Initial: _____

New York Family Dental Arts
340 East 72nd Street
New York, NY 10021

Help us get to know you by answering the following questions:

When I think about coming to the dentist I feel:

- ☐ Comfortable – I have no anxiety about seeing the dentist or dental procedures
- ☐ Anxious – I don't want to come but I make myself, however I am seldom comfortable
- ☐ Fearful – I have stayed away from the dentist because of my fear and avoid coming unless absolutely necessary
- ☐ Extremely fearful – I cannot cope with dental visits and have avoided the dentist for years to the detriment of my dental health

I have avoided the dentist because of:

- ☐ My anxiety and fear
- ☐ Other _____
- ☐ Cost
- ☐ Past experiences

My childhood dental experiences were:

- ☐ Completely pain free and comfortable
- ☐ I did not go to the dentist as a child
- ☐ Somewhat uncomfortable
- ☐ Traumatic
- ☐ Painful

My dental experiences as an adult have been:

- ☐ Completely pain free and comfortable
- ☐ Somewhat uncomfortable
- ☐ I have not seen the dentist as an adult or my visits have been very few
- ☐ Painful
- ☐ Traumatic

I have a fear of – I have concerns about:

- ☐ Experiencing pain
- ☐ Needles
- ☐ Gagging
- ☐ Losing my teeth
- ☐ Catching a disease
- ☐ Having to wear a denture or partial
- ☐ Not being numb
- ☐ Unnecessary or wrong treatment
- ☐ Losing control
- ☐ Being scolded or made to feel ashamed
- ☐ Having something put over my mouth
- ☐ Other _____

The following makes me uncomfortable:

- ☐ The sounds of a dental drill
- ☐ The smells in a dental office
- ☐ Having to wait in the reception room
- ☐ Laying down in a dental chair
- ☐ Being numb
- ☐ Other _____

The following things are important to me:

- ☐ Getting as much work done in as few appointments as possible
- ☐ Temperature of the treatment rooms
- ☐ Available financing
- ☐ Being able to use my insurance benefits
- ☐ Being able to watch TV or listen to music while having dental work done
- ☐ Being offered a pillow and blanket for my comfort
- ☐ Having Nitrous Oxide available
- ☐ Privacy issues
- ☐ Other _____

My preference would be:

- ☐ To be told in detail about what is going on in my mouth
- ☐ To be told in general terms what is going on in my mouth
- ☐ To be shown pictures so that I can understand and see what is going on in my mouth
- ☐ To read pamphlets and/or books to get more information about my dental problems and solutions
- ☐ To dialogue with a team member about my dental problems and solutions
- ☐ Other _____

My immediate concern about my teeth and my smile is: _____

NEW YORK FAMILY DENTAL ARTS, PC

CANCELATIONS: Because of our commitment to providing the best possible experience to our patients, we require 24 hours advance notice to reschedule or cancel appointments; as such there is a $150 fee for missed appointments or appointments rescheduled or canceled on the same day. **INITIAL** _____

INSURANCE POLICY: As we all know, insurance companies always have their own agenda in what they choose to cover and not cover. However, it is our office policy to provide individual needs-based care and not insurance dictated care. Therefore, we choose to participate in accepting their benefits, but we do not choose to follow their guidelines when it comes to examining our individual patients. We currently participate with most PPO dental insurance carriers, however, co-payments and/ or deductibles are due at the time of service according to your insurance plan benefits. If you are unsure of what your dental benefits are please call your insurance carrier for benefit information. **INITIAL** _____

PROCESSING OF CLAIMS: Insurance Claims are submitted electronically at the end of your appointment, any co-payments charged are ***ESTIMATES** according to your plans fee schedule and not a guarantee of payment. Claim processing should take around 4-6 weeks from date of service.

PAYMENT: We accept Visa, Mastercard, American Express, Discover, CareCredit, Checks and Cash payments. **Payment in full is due to New York Family Dental Arts at the time of service**. If we are within your network as participating providers the remaining balance after your deductible has been met and co- payments (if applicable) have been satisfied a claim form is then submitted to your dental carrier for payment on your remaining balance.

EMERGENCIES: If you have an emergency after hours please call our office at 212-628-3300 and listen for our doctor's emergency contact number.