PATIENT REGISTRATION AND HEALTH HISTORY

DATE_____

PATIENT'S NAME _____DATE OF BIRTH _____
MINOR MARRIED SINGLE MALE FEMALE

IF COMPLETING THIS FORM FOR ANOTHER, YOUR RELATIONSHIP_____

SPOUSE, PARENT'S OR GUARDIAN'S NAME_____

ADDRESS_____APT #_____TOWN_____ZIP_____

HOME PHONE _____BUSINESS PHONE_____

CELLULAR PHONE_____E-MAIL ADDRESS_____

WHAT IS YOUR OCCUPATION ? _____

BUSINESS NAME AND ADDRESS _____

PATIENT'S SOCIAL SECURITY NUMBER _____

PATIENT'S DRIVER LICENSE NUMBER & STATE_____

PERSON TO CONTACT IN CASE OF EMERGENCY _____
RELATIONSHIP TO PATIENT_____TELEPHONE #:( )_____

DO YOU HAVE ANY DENTAL INSURANCE OR COVERAGE ? YES / NO

HAS YOUR DENTAL INSURANCE CHANGED SINCE LAST APPT.? YES / NO

INSURANCE INFO. PRIMARY INS. CO SECONDARY INS CO.
EMPLOYEE NAME _____
EMPLOYEE SS # _____
EMPLOYEE DATE OF BIRTH_____
SPOUSE'S EMPLOYER'S NAME AND ADDRESS _____

SPOUSE'S WORK TELEPHONE NUMBER ( )_____

PERSON RESPONSIBLE FOR PAYMENT _____

NUMBER OF CHILDREN IN FAMILY_____AGES_____

PAST MEDICAL / DENTAL HEALTH HISTORY

PHYSICIAN'S NAME AND ADDRESS_____

ARE YOU CURRENTLY UNDER HIS CARE_____ IF SO FOR WHAT ? _____

ANY CHANGE IN YOUR MEDICAL HISTORY IN THE PAST YEAR ? WHAT ?_____
PHYSICAL EXAMINATION DATE_____
BLOOD PRESSURE_____/_____

MEDICAL CONDITION: EXCELLENT GOOD FAIR POOR

NAME OF LAST DENTIST / TOWN _____

DATE OF LAST DENTAL EXAMINATION _____

PHARMACY NAME, LOCATION, TELEPHONE # _____
NAME OF ORAL SURGEON I HAVE USED _____
LOCATION_____

PLEASE INITIAL	YES	NO
ANY SERIOUS TROUBLE ASSOCIATED WITH DENTAL TREATMENT	_____	_____
ANY PAIN OR DISCOMFORT (HOT, COLD, ETC.) IF SO, WHERE	_____	_____
DO YOU WEAR REMOVABLE DENTAL APPLIANCES	_____	_____
ANYTHING YOU DISLIKE ABOUT YOUR SMILE	_____	_____
DO YOU WANT TO WHITEN/BRIGHTEN YOUR SMILE	_____	_____
HOSPITALIZED EVER ?	_____	_____
IF SO, FOR WHAT ? _____		
ANY MEDICATION PRESENTLY	_____	_____
IF SO WHAT ? _____		
ALLERGY OR SENSITIVITIES	_____	_____
TO ANY MEDICINES/FOODS	_____	_____
IF SO , WHAT ? _____		
SUBJECT TO PROLONGED BLEEDING		
SLEEP WITH 2-3 PILLOWS	_____	_____
ANY PROBLEMS WITH ANESTHETICS	_____	_____
DO YOU HAVE A HEART MURMUR	_____	_____
DO YOU HAVE AN ARTIFICIAL JOINT	_____	_____
DO YOU HAVE DENTAL IMPLANTS	_____	_____
DO YOU HAVE NIGHT SWEATS OR LOSS OF WEIGHT ?	_____	_____
DO YOU HAVE ANY EATING DISORDERS	_____	_____
WHEN YOU WALK UP THE STAIRS, DO YOU HAVE TO STOP BECAUSE OF PAINS IN YOUR CHEST OR SHORTNESS OF BREATH ?	_____	_____
DO YOU HAVE CARDIOMYOPATHY (HEART FAILURE)	_____	_____
HAVE YOU USED DIET PILLS - FEN-PHEN/REDUX?	_____	_____

PLEASE CIRCLE ANY OF THE ILLNESS YOU HAVE HAD AND DATE

CONGESTIVE HEART FAILURE	MONONUCLEOSIS	MENINGITIS
HEART FAILURE	EMPHYSEMA	AIDS / HIV POSITIVE
HEART DISEASE OR ATTACK	INFECT. HEPATITIS	SERUM HEPATITIS
ANGINA PECTORIS	TUBERCULOSIS [TB]	COUGH PERSISTENT
HIGH /LOW BLOOD PRESSURE	ASTHMA	LIVER DISEASE
HEART MURMUR	HAY FEVER	YELLOW JAUNDICE
RHEUMATIC FEVER	SINUS TROUBLE	BLOOD /TRANSFUSION
CONGENITAL HEART LESION	ALLERGIES/HIVES	DRUG ADDICTION
SCARLET FEVER	DIABETES	HEMOPHILIA
ARTIFICIAL HEART VALVE	THYROID DISEASE	V.D. / VENEREAL DISEASE
HEART PACEMAKER	RADIATION THERAPY	COLD SORES
HEART SURGERY	CHEMOTHERAPY	GENITAL HERPES
ARTIFICIAL JOINT	ARTHRITIS	SEIZURES
BY-PASS SURGERY-HEART	DIARRHEA	UNKNOWN FEVER
MITRAL VALVE PROLAPSE	RHEUMATISM	FAINTING/DIZZY
STROKE	CORTISONE MEDICATION	NERVOUSNESS
KIDNEY TROUBLE	GLAUCOMA	PSYCHIATRIC TMT.
ULCERS	PAIN IN JOINTS	BRUISE EASILY
NOSE BLEEDS	ANKLE SWELLING	JAUNDICE
BLOOD TEST-RECENT	INSOMNIA	HEPATITIS - VIRAL
ARC-AIDS RELATED COMPLEX	ORAL FUNGUS	EPILEPSY
PROLONGED BLEEDING	FAINT OFTEN	ANEMIA
BIRTH CONTROL PILLS	LYME DISEASE	OSTEOPOROSIS
BRONCHITIS	PNEUMONIA	FOOD IMPACTION
MOBILE (LOOSE) TEETH	BLEEDING GUMS	PREGNANT # MO._____
LUPUS ERYTHEMATOSUS	DRY MOUTH	BREATH ODOR
LONG TERM USE OF BREATH MINTS	PAST PREMEDICATIONS	OTHER SERIOUS ILLNESS
SMOKE - CIGARETTES---PIPE---CIGARS	SWOLLEN NECK GLANDS	SCARLET FEVER
LATEX ALLERGY		

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE_____

THE UNDERSIGNED AGREES THAT ALL THE STATEMENTS ON THIS FORM ARE CORRECT AND I WILL NOTIFY THE OFFICE OF ANY CHANGES.

SIGNATURE OF PATIENT OR GUARDIAN_____DATE_____

REVIEWED BY DOCTOR_____

PARK SLOPE FAMILY DENTISTRY P.C.

245 FIFTH AVENUE
BROOKLYN, NEW YORK 11215
718~789~5700

PATIENT'S NAME_____ DATE_____

I HAVE READ , UNDERSTAND AND AGREE TO THE STATEMENTS BELOW:

[A] TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEEDING ANSWERS PERTAINING TO MY/ CHILD'S / MINOR'S MEDICAL HISTORY ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGES IN THE MEDICAL HISTORY, OR MY MEDICINES/ MEDICATIONS CHANGE, I WILL INFORM PARK SLOPE FAMILY DENTISTRY PC AT THE NEXT APPOINTMENT WITHOUT FAIL IN WRITTEN FORM SO THAT IT CAN BE INCORPORATED INTO MY PREVIOUS MEDICAL HISTORY.

[B] I UNDERSTAND THAT ALL DENTAL SERVICES OR PROCEDURES MAY NOT BE FULLY COVERED BY THE INSURANCE OR UNION EMPLOYMENT DENTAL PLANS. I/WE AGREE TO PAY FOR ALL SERVICES OR PROCEDURES NOT COVERED BY INSURANCE OR DENTAL PLANS. I AUTHORIZE TREATMENT AND AGREE TO PAY ALL FEES AND CHARGES FOR TREATMENT ON THIS PATIENT. I GIVE PARK SLOPE FAMILY DENTISTRY PC THE AUTHORITY TO SIGN THE INSURED'S NAME TO A DENTAL INSURANCE CLAIM FORM SHOULD I FORGET TO GIVE HIM A PROPERLY FILLED OUT FORM.

[C] I AUTHORIZE TREATMENT AND AGREE TO PAY IN FULL ALL FEES AND CHARGES FOR TREATMENT ON THIS PATIENT AT THE TIME OF SERVICE. I UNDERSTAND THAT IF I SHOULD BE DELINQUENT WITH PAYMENT OF ANY PORTION OF MY AND OR MY FAMILY'S BALANCES BEYOND 30 DAYS THERE WILL BE AN INTEREST CHARGE PLACED ON THE ACCOUNTS IN THE AMOUNT OF 1 1/2 % PER MONTH. IF THE BALANCE IS NOT PAID AND THUS LEGAL ACTION IS TAKEN, I SHALL PAY ALL COSTS OF COLLECTION. I UNDERSTAND THAT IF THE BANK RETURNS MY CHECK TO PARK SLOPE FAMILY DENTISTRY PC'S OFFICE FOR INSUFFICIENT FUNDS, THAT I SHALL BE RESPONSIBLE FOR A $25.00 RETURN FEE.

[D] I UNDERSTAND THAT FROM TIME TO TIME THERE IS A POSSIBILITY THAT ANOTHER DENTIST WILL RENDER TREATMENT TO THE PATIENT IN PARK SLOPE FAMILY DENTISTRY PC'S OFFICE. THIS DENTIST IS INDEPENDENT OF DRS. WARSHAW & ROSENWEIN AND COMPLETELY CONTROLS THE TREATMENT RENDERED TO THE PATIENT.

[E] *FOR FEMALES* - I UNDERSTAND THAT IF I TAKE ANTIBIOTICS OR OTHER MEDICATIONS, I.E., PENICILLIN, ERYTHROMYCIN, TRANQUILIZERS, ETC., DURING THE TIME THAT I AM TAKING BIRTH CONTROL PILLS, I MUST USE AN ALTERNATE METHOD OF CONTRACEPTION DURING THAT PERIOD AND FOR THE TIME AFTER TERMINATION OF THE MEDICATION, UNTIL MY NEXT MENSTRUAL CYCLE.

X_____
PATIENT, PARENT OR GUARDIAN'S SIGNATURE DATE

RELATIONSHIP TO PATIENT _____

Park Slope Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this Acknowledgment

I, _____, have received a copy of this Office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communication barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify)

_____

_____

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