



80-15 Myrtle Avenue
Glendale, NY 11385
(718)821-4680
www.forestparkdental.net

Today's Date: _____

Name : _____

Last

First

Middle

Preferred Name

Title: Mr. Ms. Mrs.

Position: Single Married Child Widowed Divorced

Date of Birth: _____ Social Security Number: _____

Address: _____ Apt _____

Home Phone: _____ Cellular Phone: _____

E-Mail address: _____

In case of emergency, who should be notified? _____

Phone number: _____

Employer: _____

Employer Address: _____ Occupation: _____

Employer Phone: _____

Person responsible for this account: _____

Name of Dental Insurance Company: _____

Name of Policyholder: _____

Relationship to Patient: Self Spouse Child Other

Policy Number: _____ Group Number/Name: _____

Whom may we thank for referring you? Please give first and last name: _____

Medical History

Physician's Name: _____ Phone: _____

Office Address: _____

Date of last physical: _____

Are you currently or have you recently been under the care of a physician? No Yes - If yes, please explain _____

Please describe your general health: Good Poor

Have you ever been hospitalized? No Yes – please explain: _____

Women – Are you pregnant? No Yes – If yes, please indicate due date _____

Are you nursing? No Yes

Please list all medications, drugs or pills you are presently taking: _____

Is there anything else we should know about your medical history? _____

Have you had any adverse reaction to anesthesia? No Yes – please explain _____

Have you ever responded adversely to medical or dental treatment? No Yes – please explain: _____

Have you ever had any of the following?

Yes No

- Anemia
- Anorexia
- Arthritis
- Asthma
- Back Problems
- Bleeding Tendency
- Blood Disease
- Bulemia
- Cancer
- Chemical Dependency (Drug or Alcohol Addiction)
- Chemotherapy
- Chicken Pox
- Chronic Fatigue Syndrome
- Circulatory Problems
- Colitis
- Congenital Heart Lesions
- Convulsions or Fits
- Cough (persistent or bloody)
- Diabetes
- Emotional Difficulty
- Emphysema

Yes No

- Epilepsy
- Fainting or Dizziness
- Glandular Problem
- Glaucoma
- Heart Murmur
- Heart Disease
- Hepatitis – Type _____
- Hernia
- Herpes
- High Blood Pressure
- HIV/AIDS
- Jaundice
- Kidney Disease
- Latex Allergy
- Liver Disease
- Low Blood Pressure
- Measles
- Migraine Headaches
- Mitral Valve Prolapse
- Mumps
- Multiple Sclerosis
- Pacemaker

Yes No

- Pneumonia
- Polio
- Prostate Problems
- Psychiatric Disorder
- Respiratory Disease
- Rheumatic Fever
- Scarlet Fever
- Seizures
- Shortness of Breath

Yes No

- Sinus Trouble
- Skin Rash
- Stroke
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Ulcers
- Venereal Disease

Anything else that is not listed: _____

Do you have any of the following allergies?

Yes No

- Aspirin
- Barbiturates
- Codeine
- Cortisone

Yes No

- Local Anesthetics (ex: Novocaine)
- Penicillin or other antibiotics
- Sedatives
- Sulfa Drugs

Anything else that is not listed: _____

Dental History

Please explain the reason for your visit today: _____

Have you noticed (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Change in color of gums | <input type="checkbox"/> Change in Color of Teeth |
| <input type="checkbox"/> Bleeding or Swollen Gums | <input type="checkbox"/> Spaces Developing Between Teeth |
| <input type="checkbox"/> Bad Mouth Odor or Taste | <input type="checkbox"/> Food Catching Between Teeth |
| <input type="checkbox"/> Teeth Tender When Chewing | <input type="checkbox"/> Swelling or Lump in Mouth |
| <input type="checkbox"/> Teeth Sensitive to Hot or Cold | <input type="checkbox"/> Change in Appearance of Face |
| <input type="checkbox"/> Unusual Sounds in Ear While Eating | <input type="checkbox"/> Burning of Tongue |
| <input type="checkbox"/> Pain Around Ear | <input type="checkbox"/> Frequent Blisters on Lips or Mouth |
| <input type="checkbox"/> Teeth Sensitive to Sweets | |

Anything else that is not listed: _____

Are you now experiencing pain in your mouth? No Yes – For how long? _____

When did you last visit a dentist? _____

Reason for changing dentist? _____

When did you last have your teeth cleaned? _____

Do you or have you ever worn a denture or partials? _____

Are you aware of clenching or grinding your teeth? _____

Have you ever had treatment for a tumor or growth in or around your mouth? No Yes

If you could change anything about your teeth or smile, what would it be? _____

The information provided on this form is complete and correct. I understand that it is my responsibility to inform the doctor if I have a change in health.

Patient/Guardian Signature _____ Date: _____

Relation to patient: _____

Financial Responsibility and Release of Information

Appointments: A charge of \$25 will be made for failed or canceled appointments without 24 hours advance notice.

Insurance benefits are determined by your employer, not your dentist. I understand that I am financially responsible to Forest Park Dental for charges not covered by my insurance carrier. Payment for services is due at time of service. I also agree that, should I fail to assume this financial responsibility and credit action is necessary, I will pay for these costs in addition to the amount of the doctor's charges.

I authorize Forest Park Dental to release to the Social Security Administration or its intermediaries or carriers, or other insurance carrier any medical or other information needed for this or a related insurance claim. I authorize the use of this signature on all insurance submissions.

Co-payments and Deductibles: Our contract with your insurance company requires that we collect co-payments and deductibles at time of service.

Insufficient Funds Checks: Forest Park Dental will bill the patient \$30 in addition to the amount of the check.

By signing below, I understand and agree to comply with the financial policies of Forest Park Dental.

Patient/Guardian Signature _____ Date: _____

Relation to patient: _____