

# GENERAL PATIENT INFORMATION

Please Print Out Our New Patient Registration Form, Fill It Out, And Bring It With You To Your Appointment. For Your Convenience, Our Directions Are On The Last Page.

## Patient Registration

### Patient Information

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Marital Status:            Single            Married            Separated            Divorced            Widowed

Sex:                        Male                Female

SSN/ID: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

### Drivers License

State: \_\_\_\_\_

Number: \_\_\_\_\_

### Home Address:

Address: \_\_\_\_\_

City, State and ZIP: \_\_\_\_\_

### Billing Address:

Address: \_\_\_\_\_

City, State and ZIP: \_\_\_\_\_

### Work Information

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Method of Contact:            Phone            Email            Text Message            Any of the previous ones

### Emergency Contact:

Full Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relation: \_\_\_\_\_

### How did you hear about our office?

Who may we thank for referring you? \_\_\_\_\_

# GENERAL PATIENT INFORMATION

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## Financial Information

### Patient's Payment Details – Guarantor (Person responsible for paying the bill)

Guarantor Name: \_\_\_\_\_

SSN/ID: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

### Patient's Student Status

Student Status: \_\_\_\_\_

College: \_\_\_\_\_

College Address: \_\_\_\_\_

### Primary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN/ID: \_\_\_\_\_

Employer: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Coverage Type:                      Individual              Family              Prepaid / Capitation

Insurance Company: \_\_\_\_\_

Company Phone Number: \_\_\_\_\_

Company City, State, ZIP: \_\_\_\_\_

### Secondary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN/ID: \_\_\_\_\_

Employer: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Coverage Type:                      Individual              Family              Prepaid / Capitation

Insurance Company: \_\_\_\_\_

Company Phone Number: \_\_\_\_\_

Company City, State, ZIP: \_\_\_\_\_

### Pharmacy Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

**Medicaid Number:** \_\_\_\_\_

I authorize the dentist to release any information, including diagnosis, treatment plans/records and radiographs to third party payers and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the dental group or dentist benefits that are, otherwise, payable to me. I understand that my dental insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies.

Signature: \_\_\_\_\_

# PATIENT MEDICAL HISTORY

## Patient's Medical History

### Physician Information

Physician's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State and ZIP: \_\_\_\_\_

Are you currently under a physician's Care?      Yes      No

If Yes, for what?

Have you been hospitalized in the last two years?      Yes      No

If Yes, for what?

Are you taking any medication, drugs or pills?      Yes      No

If so, please list the names and dosages of each:

Do you Smoke?      Yes      No      How Much?      \_\_\_\_\_

### Women Only

Are you pregnant?      Yes      No      What is your due date? \_\_\_\_\_

Are you nursing?      Yes      No      Are you taking birth control pills?      Yes      No

Are you on Hormone Therapy?      Yes      No

## Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

### Medical Alerts

Allergic to Penicillin	Allergic to Codeine	Pre-Medication required	Pacemaker
Allergic to Tetracycline	Allergic to 'Novocaine'	Mitral Valve Prolapse	HIV Positive
Allergic to Aspirin	Allergic to Latex Rubber	Heart Problems	Prior Hepatitis

Other

### Medical Conditions

Heart Attack	Excessive Bleeding when Cut	Chemotherapy	Osteoporosis
Heart Murmur	Sickle Cell Disease	Ulcers	Swelling of Feet/Ankles
Chest Pain	Glaucoma	Gastrointestinal Upset	Artificial Joint Replacement
Congenital Heart Problem	Diabetes	Acid Reflux	Psychiatric Care
Artificial Heart Valve	Excessive Thirst	Lung Disease	Epilepsy or Seizures
Heart Surgery	Scarlet Fever	Tuberculosis	Extreme Nervousness
High/Low Blood Pressure	Thyroid Disease	Shortness of Breath	Fainting or Dizziness
Rheumatic Fever	Parathyroid Disease	Emphysema	Hypoglycemia
Anemia	Kidney Disease	Asthma	Hives
Blood Disease	Liver Disease	Sinus Trouble	Cold Sores/Fever Blisters
Blood Transfusion	Hepatitis A or B	Hay Fever	Venereal Disease
Stroke	Yellow Jaundice	Frequent Cough	Herpes
Deep Vein Clot	Cancer	Rheumatism	HPV (Human Papillary Virus)
Hemophilia	X-Ray or Cobalt Treatment	Arthritis/Gout	Cortisone Treatment
			Chemical Dependency

# PATIENT DENTAL HISTORY

## Patient's Dental History

What is your primary reason for seeking dental care?

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### Previous Dentist Information

Dentist's Full Name: \_\_\_\_\_

City, State and ZIP: \_\_\_\_\_

Month and Year of Last Visit: What \_\_\_\_\_

was done at your last visit? Date of \_\_\_\_\_

Last full mouth x-rays: Reason for \_\_\_\_\_

leaving previous dentist: How often \_\_\_\_\_

do you visit the dentist?                      Annual Check Up                      Twice a Year Check Up  
   Only when I have a problem                      Other

### Please choose the appropriate answer

Are you nervous about receiving dental treatment?	Yes	No	Are you missing teeth that have not been replaced?	Yes	No
Do you gag easily?	Yes	No	Have you had excessive bleeding after an extraction?	Yes	No
Have you had previous problems with dental care?	Yes	No	Have you had mouth sores that take long to heal?	Yes	No
If so, please explain?			Do you have any dental implants?	Yes	No
<div style="border: 1px solid black; height: 40px; width: 100%;"></div>			Do you wear dentures (partials or full)?	Yes	No
			Do you have any crowns (caps) or bridges?	Yes	No
			Do you chew tobacco?	Yes	No
Are your teeth sensitive to hot, cold, pressure or sweets?	Yes	No	Do you have a dry mouth?	Yes	No
Do you have problems with teeth/fillings breaking?	Yes	No	Are you unhappy with the appearance of your teeth?	Yes	No
Are you aware of an uncomfortable bite?	Yes	No	Would you like your smile to look better?	Yes	No
Do your gums feel tender and/or bleed?	Yes	No	Would you like whiter teeth?	Yes	No
Does food catch between your teeth?	Yes	No	Do you regularly use dental floss?	Yes	No
Have you had periodontal (gum) treatments?	Yes	No	Do you brush at least once daily?	Yes	No
Do you get sores in or around your mouth?	Yes	No			
Do you have regular headaches, earaches or neck pains?	Yes	No			
Do you grind or clench your teeth?	Yes	No	Is there anything else that you would like us to know?		
Do you hear a "clicking" sound when you open/close your mouth?	Yes	No	<div style="border: 1px solid black; height: 60px; width: 100%;"></div>		
Does your jaw ever get "stuck"?	Yes	No			
Do you have a Temporomandibular(TMJ) jaw disorder?	Yes	No			

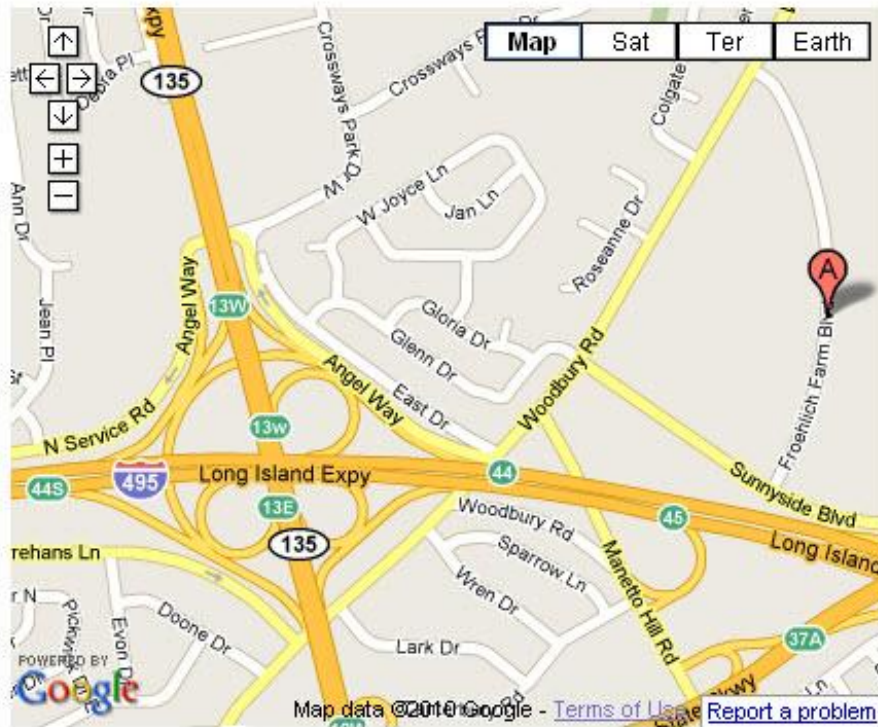
I authorize the use of my radiographs [x-rays] and/or photographs for educational and promotional use in seminars, publications and the dental office web site. Yes    No

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature: \_\_\_\_\_

**Dr. Joel Keschner  
Dr. Amy Zuker  
www.MyWoodburyDentist.com  
Ph: 516-293-5050 Fax: 516-921-4797**

Our office is located at 171 Froehlich Farm Blvd, Woodbury, NY 11797 and can be reached conveniently from both the Long Island Expressway and the Northern State Parkway, or from Woodbury Road (see below).



**Directions:**

**From the East:**

Northern State Parkway to exit 38. At exit, turn left onto Sunnyside Blvd. Turn right onto Froehlich Farm Blvd. Turn left at the 4<sup>th</sup> building on the left side of the street (#135-175 – look for the big “Inter Reco” sign) and proceed to the back of the building. We are Suite #171.

Long Island Expressway (495) to Sunnyside Blvd (exit 46). Take the service road to the light and turn right onto Sunnyside Blvd. Follow Sunnyside Blvd. to Froehlich Farm Blvd. and follow as above.

**From the West:**

Northern State Parkway to exit 38. Turn right onto Sunnyside Blvd. and proceed as above. LIE to exit 46. Service Road to light. Left at light onto Sunnyside Blvd., and proceed as above.