Steinway Family Dental Center

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:______________________ Apt. ______ City: ________ State:________ Zip: __________

Home Phone:______________ Cell:______________ E-mail: ______________________

SS #:______________ Employer/Occupation:______________ Work Phone: ______________

Pharmacy: ______________ Pharmacy Phone #: ______________________

Whom may we thank for referring you? **(Check Below)**

Google **Flyer by Mail** **Flyer by Person** **TV Commercial** **Insurance**

Passing By **Zocdoc** **Friend/Family: ____________________** **Other: _________________**

INSURANCE INFORMATION

Primary dental insurance: ______________________________________

Cardholder:______________ Relationship to patient:__________ Cardholder's date of birth:__________

SS #:______________ Insurance ID #:______________ Group #:______________

Name of dependents covered on this plan: ______________________________________

Secondary dental insurance (if applicable): ______________________________________

Cardholder:______________ Relationship to patient:__________ Cardholder's date of birth:__________

SS #:______________ Insurance ID #:______________ Group #:______________

Name of dependents covered on this plan: ______________________________________

I, the undersigned, certify that I (or my dependents) have insurance coverage with ______________________ and assign directly to Steinway Family Dental Center all insurance, benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I further authorize Steinway Family Dental Center to share information about my health with other medical professionals and laboratories.

______________________ ______________________ ______________________
Responsible party's signature Relationship Date

Dental Health History

Reason for today's visit: ______________________________________

Former dentist: ______________________________________

Address: ______________________________________

Date of last Dental Care:______________ Date of last dental x-rays: ______________________

TURN PAGE

Question	YES	NO
Have you had problems with previous dental Treatment?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty chewing your food?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Are you experiencing bad breath?	☐	☐
Do you grind your teeth?	☐	☐
Do you have loose teeth and/or broken fillings?	☐	☐
Have you had any periodontal (gum) treatment	☐	☐

Question	YES	NO
Do you feel pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours or Sweets?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
How often do you brush?		
How often do you floss?		
Do you take medications or pills for pain or discomfort?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐

Medical Health History:

Do you have, or have you had, any of the following? Check Yes or No.

Yes	No	Condition
☐	☐	AIDS
☐	☐	Artificial Heart Valves
☐	☐	Back problems
☐	☐	Chemical Dependency
☐	☐	Cortisone Treatments
☐	☐	Diabetes
☐	☐	Glaucoma
☐	☐	Heart Problems
		Describe: ______________
☐	☐	Hepatitis
☐	☐	Jaw Pain
☐	☐	Mitral valve prolapse
☐	☐	Psychiatric care
☐	☐	Rheumatic Fever
☐	☐	Skin Rash
☐	☐	Thyroid Problems
☐	☐	Ulcer
☐	☐	Anemia

Yes	No	Condition
☐	☐	Artificial Joints
☐	☐	Blood disease
☐	☐	Chemotherapy
☐	☐	Persistent Cough
☐	☐	Epilepsy
☐	☐	Headaches
☐	☐	High Blood Pressure
☐	☐	Kidney Disease
☐	☐	Nervous Problems
☐	☐	Radiation Treatment
☐	☐	Scarlet Fever
☐	☐	Stroke
☐	☐	Tonsillitis
☐	☐	Venereal Disease
☐	☐	Arthritis, Rheumatism
☐	☐	Asthma
☐	☐	Cancer

Yes	No	Condition
☐	☐	Circulatory Problems
☐	☐	Cough Up Blood
☐	☐	Fainting
☐	☐	Heart Murmur
☐	☐	Hemophilia
☐	☐	HIV Positive
☐	☐	Liver Disease
☐	☐	Pacemaker
☐	☐	Respiratory Disease
☐	☐	Shortness of Breath
☐	☐	Swelling of Ankles
☐	☐	Tuberculosis
☐	☐	Autism
☐	☐	Other: ______________

Are you currently taking any medications? (Please specify) ____

____

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

	YES	NO
Local anesthetics	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other: ______________________		

Women

	YES	NO
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant? If so, expected delivery date: ______________	☐	☐
Are you nursing?	☐	☐

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any error or omissions that I may have had in the completion of this form.

Date: ____________________________ Signature: ________________________________