Smiles On Wellwood

764 N. Wellwood Avenue, Lindenhurst, NY 11757
(631) 957-2211

REGISTRATION AND MEDICAL HISTORY

DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____ HOME PHONE _____

ADDRESS _____ BUS. PHONE _____

CITY, STATE, ZIP _____ EMAIL _____

IF CHILD, PARENT'S NAME _____ SINGLE ☐

OCCUPATION _____ SS # _____ MARRIED ☐

PATIENT EMPLOYED BY _____ DIVORCED ☐

BUSINESS ADDRESS _____

IN CASE OF EMERGENCY WHOM SHOULD BE NOTIFIED _____

_____ PHONE _____

DO YOU HAVE ANY INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES? _____

NAME OF PRIMARY _____

ADDRESS _____

POLICY # _____ GROUP # _____

PATIENTS RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐

INSURED NAME _____

INSURED SS # _____ D. O. B. _____

INSURED EMPLOYER _____

EMPLOYER'S ADDRESS _____

_____

NAME OF PRIMARY _____

ADDRESS _____

POLICY # _____ GROUP # _____

PATIENTS RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐

INSURED NAME _____

INSURED SS # _____ D. O. B. _____

INSURED EMPLOYER _____

EMPLOYER'S ADDRESS _____

_____

PLEASE NOTE: Patients with insurance that will only reimubrse the member, or any patient who receives insurance checks will have 14 days from the date they receive check to forward the check to our office. If check is not received withing 14 days, the patient will be billed for our private fees for their visit. Thank you for your cooperation

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PHYSICIAN'S NAME _____ PHONE _____

ADDRESS _____

Continued on next page (OVER) →

DENTAL HISTORY

Do you smoke? YES ☐ NO ☐
packs per day? _____

Why have you come to the dentist today?

_____

_____

_____

Do you require antibiotics before dental treatment? YES ☐ NO ☐

Are you currently in pain? YES ☐ NO ☐

Have you ever had a serious/ difficult problem with any previous dental work? YES ☐ NO ☐

Do you now or have you ever experienced pain/discomfort in your jaw point(TMJ/TMD)? YES ☐ NO ☐

Your current dental health is? Good ☐ Fair ☐ Poor ☐

Do you like your smile? YES ☐ NO ☐

Do your gums ever bleed? YES ☐ NO ☐

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of Bristles? Soft ☐ Medium ☐ Hard ☐

Notes:

_____

_____

_____

_____

_____

_____

_____

_____

Are you allergice to any of the following?

YES ☐ NO ☐ Aspirin
YES ☐ NO ☐ Codeine
YES ☐ NO ☐ Dental Anesthetics
YES ☐ NO ☐ Erythromycin
YES ☐ NO ☐ Penicillin
YES ☐ NO ☐ Sulfa
YES ☐ NO ☐ Tetracycline
Other Allergies: _____

_____

Are you/Have you taken any DIET DRUGS (Example: Fen-Phen)

Are you/Have you taken any medication for OSTEOPOROSIS or CHEMOTHERAPY?
(Examples: Fosamax, Actonel, Boniva, Skelid, Didronel) YES ☐ NO ☐

If YES, then did you take it by:
MOUTH (PILL) YES ☐ NO ☐
IV (NEEDLE) YES ☐ NO ☐

PLEASE CHECK

YES ☐ NO ☐ HEART PACEMAKER
YES ☐ NO ☐ HEART DISEASE
YES ☐ NO ☐ SYPHILLIS
YES ☐ NO ☐ ANGINA
YES ☐ NO ☐ RHEUMATIC FEVER
YES ☐ NO ☐ HEART MURMUR
YES ☐ NO ☐ HERPES
YES ☐ NO ☐ AIDS
YES ☐ NO ☐ HEPATITIS
YES ☐ NO ☐ STROKE
YES ☐ NO ☐ DIEABETES
YES ☐ NO ☐ JAUNDICE
YES ☐ NO ☐ HIV POSITIVE
YES ☐ NO ☐ GONORRHEA

YES ☐ NO ☐ EPILEPSY/SEIZURE DISORDER
YES ☐ NO ☐ HEART VALVE REPLACEMENT
YES ☐ NO ☐ X-RAY OR CHEMOTHERAPY
YES ☐ NO ☐ DO YOU DRINK ALCOHOLIC BEVERAGES
YES ☐ NO ☐ OFFENSIVE BREATH
YES ☐ NO ☐ DO YOU OR HAVE TAKEN DRUGS
YES ☐ NO ☐ PROLONGED BLEEDING
YES ☐ NO ☐ BLOOD TRANSFUSION
YES ☐ NO ☐ PROLAPSED MITRAL VALVE
YES ☐ NO ☐ ABNORMAL APRESSURE
YES ☐ NO ☐ CONGENITAL HEART LESIONS-DEFECTS
YES ☐ NO ☐ ULCERS
YES ☐ NO ☐ HAY FEVER
YES ☐ NO ☐ SINUS PROBLEMS

YES ☐ NO ☐ PERSISTENT COUGH
YES ☐ NO ☐ ASTHMA
YES ☐ NO ☐ EMPHYSEMA
YES ☐ NO ☐ ANEMIA
YES ☐ NO ☐ GLAUCOMA
YES ☐ NO ☐ KIDNEY DISEASE OR DIALYSIS
YES ☐ NO ☐ ANY TRANSPLANTED ORGANS
YES ☐ NO ☐ ANY COMMUNICABLE DISEASES
YES ☐ NO ☐ PIN, ROD OR ANY FOREGN OBJECT IMPLANTED IN YOUR BODY

ANYTHING NOT LISTED, IF SO PLEASE LIST:

_____

_____

_____

FOR WOMEN ONLY

Are you pregnant? YES ☐ NO ☐
Are you nursing? YES ☐ NO ☐
Are you taking birth control pills? YES ☐ NO ☐

I, DR. _____ ,have verbally reviewed the medical/dental information above with the patient named herein.

I certy that i have read and understand the above and all answers are correct. If I have any change in my health or medication, i will inform you immediately.

_____

SIGNATURE OR PATIENT OR GUARDIAN