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: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ E-mail: _____

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

Pharmacy: _____ Pharmacy Phone #: _____

Whom may we thank for referring you? _____

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 hearby 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: _____

	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 treatment?	☐	☐

	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?

- ❑ 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
- ❑ 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
- ❑ Circulatory Problems
- ❑ Cough Up Blood
- ❑ Fainting
- ❑ Heart Murmur
- ❑ Hemophilia
- ❑ HIV Positive
- ❑ Liver Disease
- ❑ Pacemaker
- ❑ Respiratory Disease
- ❑ Shortness of Breath
- ❑ Swelling of Ankles
- ❑ Tuberculosis

Are you currently taking any medication? (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: _____