THROGS NECK DENTAL

Welcomes You

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BRONX, NY 10461
Tel: 718.518.8100
Fax: 718.430.0516
Web: throgsneckdental.com

Patient Information

Date _____ Social Security Number _____

Name _____ Email _____
Last, First, MI * We will not sell or share your information

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ Marital Status ☐ M ☐ D ☐ S ☐ P

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (_____) _____

Whom may we thank for referring you? _____

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Emergency Contact _____ Relationship _____

Contact Home (_____) _____ Contact Work (_____) _____

Primary Insurance

Subscriber Name _____

Relation to Patient _____ Birthdate _____ SS # _____

Address (if different from Patient's) _____

City _____ State _____ Zip _____ Phone (_____) _____

Person Responsible Employed By _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is Patient covered by additional insurance? ☐ Yes ☐ No Subscriber Name _____

Relationship to Patient _____ Birthdate _____ SS # _____

Address (If different from Patient's) _____

City _____ State _____ Zip _____ Phone (_____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Dental History

Reason For Today's Visit _____

Date of Last Dental Care _____

Former Dentist _____

Date of Last Dental X-rays _____

Medical History

Physician's Name _____ Date Of Last Visit _____

Have you ever taken one or more of the following medications;Fosamax, Zometa, Didrocal or Actonel? ☐ Yes ☐ No

Have you ever had any serious illness or operations? ☐ Yes ☐ No If yes,describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Place a X on "yes" or no" to indicate if you have had any of the following:

Aids/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Alcohol use	☐ Yes ☐ No	Drutg Addiction	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Frequency _____		Easily Winded	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Excessive Bleeding/	☐ Yes ☐ No	Radiation Teatment	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Abnormal Bleeding		Renal Dialysis	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No
Artifical Heart Valve	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Back/Neck Problems	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Sleep Pooly	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Attack/stroke	☐ Yes ☐ No	Snore	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Heart Trouble/Pacemaker	☐ Yes ☐ No	Street Drug	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Use/Frequency _____	
Cerebral Palsy	☐ Yes ☐ No	Hepatitas(Type _____)	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Chemical Dependecy	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tumors/Growths	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Unexplained Weight Loss	☐ Yes ☐ No
Cortizone Medicine	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

☐ Aspirin
☐ Sleeping Pills
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other: _____

I certify that the infomation provided on this form is accurate to the best of my knowledge: I, understand I am financially responsible for any charges not covered by my insurance

_____ _____

Signature of Patient, Guardian or Personal Representative Date

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's notice of privacy practices.

_____
Please print your name

_____
Signature

_____
Date

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because.

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgment.
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify)

_____
_____
_____