Patient Medical History

Your full name ____

Please answer yes or no for each as it applies to you. Use comments area if needed.
Do you now or did you ever have any of the following health conditions?

	Y/N	Comments
Diabetes	___	______________________________
Heart Murmur, Rheumatic Fever	___	______________________________
Stroke or Heart Attack	___	______________________________
Pacemaker	___	______________________________
Artificial joint replacement	___	______________________________
Asthma or Respiratory Disease	___	______________________________
Hepatitis A B or C	___	______________________________
Tuberculosis or HIV	___	______________________________
Treatment for cancer	___	______________________________
Anemia	___	______________________________
Abnormal Bleeding	___	______________________________
Epilepsy	___	______________________________
High Blood Pressure	___	______________________________
Acid Reflux Disease (GERD)	___	______________________________

I am Male / Female Are you pregnant? ________ How many months? _____

Any other health problems not listed above? ____

Please list all medications you take ____

Are you allergic to Penicillin, Nickel, other medications or substances?___________________

Physician name and telephone ____

Do you smoke? ________ Do you drink wine or other alcohol? _______

How many times a day do you brush your teeth? __________ Do you use dental floss? ______

To the best of my knowledge, all the preceding answers are true and correct.
If I ever have any changes in my health or change in my medications, I will inform the dentist at the next appointment.

Signature of Patient, Parent or Guardian:

(sign)____ Date ___________________

Ronald Birnbaum DDS MPH Dental Office, 425 West 59 Street 9B1, New York, NY 10019

Patient Registration and Dental Insurance Form

Last Name: ____

First Name: __________________________________ Middle Initial ______________

Address: ____ Apt.#_______________

City: __________________________________ State________ Zip______________

Your Email (to receive notifications) ____

Home Phone: ____________________ Work Phone: _________________________

Mobile Phone: ____________________

Emergency Contact Name and Phone ____

Your Date of Birth _________________ Your Social Security Number_________________

Your Employer Name ____

Your Employer Address ____

Are you a student? ____ FT or PT? ____ School Name, City, State_______________________

Dental Insurance Company ____

Insurance policy ID number and Group Number _____________________________________

If your dental insurance is through another person, please complete 19-24

Policyholder's Name ____

Policyholder's relationship to you _________________________

Policyholder's Home Address ____

Policyholder's Date of Birth _____________ Policyholder's SSN _____________________

Policyholder's Employer____

Policyholder's Employer Address____

a. I authorize Dr. Birnbaum to submit claims to my dental insurance company on my behalf and to accept assignment of payments. Any co-payments, deductibles and treatment not covered by insurance I will be responsible for payment upon invoice. If I am a dependent, the policyholder may be held responsible for payment.

b. I give consent for Dr. Birnbaum or his designee(s) to perform examination, diagnostic procedures and treatment. I acknowledge the potential for unanticipated/unwanted medical and/or dental outcomes arising from the use of dental anesthetics and from dental treatment or lack of treatment.

(Sign)__________________________________ **Date** ___________________