PATIENT REGISTRATION

PLEASE FILL OUT THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE:

Date _____
Name _____
Spouse _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Cell Phone _____
Email Address _____@_____
DOB ___/___/___ Age _____ Male / Female
Married ___ Single ___ Divorced ___ Widowed ___
Social Security # _____

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE:

Date _____
Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
DOB ___/___/___ Age _____ Male / Female
School _____ Grade _____
Social Security # _____

INSURANCE INFORMATION

PRIMARY CARRIER
Insurance Co:

Group # _____
Employer _____
Employee _____
DOB ___/___/___ Union or Local # _____
Employee Social Sec. # _____

SECONDARY CARRIER
Insurance Co.

Group# _____
Employer _____
Employee _____
DOB ___/___/___ Union or Local # _____
Employee Social Sec. # _____

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT
Name _____
Relationship to Patient _____
Address _____
City _____ State _____ Zip _____
Phone # _____

YOU
Name _____
Occupation _____
Employer _____
Business Address _____
Business Phone # _____

YOUR SPOUSE
Name _____
Occupation _____
Employer _____
Business Address _____
Business Phone # _____

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT OF THIS OFFICE?
Name _____
Relationship _____

REFERRED TO US BY _____

PERSON TO CONTACT FOR EMERGENCY _____
PHONE NUMBER _____
ADDRESS _____
CITY _____ STATE _____

CLOSEST RELATIVE NOT LIVING WITH YOU _____

PHONE NUMBER _____
ADDRESS _____
CITY _____ STATE _____

(PLEASE TURN OVER AND SIGN)

Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

Welcome! *So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? _____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays**_____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State_____ Zip _____

Telephone_____

How often do you have dental examinations?_____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

_____

_____

(Please complete other side)

MEDICAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or pills now? ..... Yes No
   If yes, please list name and dosage _____
4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... Yes No
   If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artifical Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/ Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Do you use more than two pillows to sleep? ..... Yes No
8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
10. **Women.** Are you: **Pregnant?** Yes, ___ Months No **Nursing**? Yes No **Taking birth control pills**? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Doctor Signature _____ Date _____

SMILES BY DESIGN

laser • aesthetic • minimally invasive dentistry

ORAL CANCER SCREENING

The incidence of oral cancer continues to rise in this country annually. Traditionally, we have done oral cancer screenings with the naked eye, but today new technology exists to diagnose oral cancer at its earliest inception. Alarmingly, 25% of oral cancer victims have no predisposing risk factors. The newest piece of technology to help us diagnose oral cancer is called the Veloscope. The Veloscope uses a special, painless laser like light, to differentiate between potentially cancerous tissue and normal tissue. The exam can be done in minutes by our hygienists, and confirmed by the doctors if something seems suspicious. The exam allows us to find any abnormalities at their earliest onset even before it is visible by the naked eye, minimizing further treatment if a result is positive.

We strongly recommend that anyone over the age of 35 undergo a routine Veloscope exam annually. If you are a smoker or chew tobacco we recommend this exam twice a year.

This exam is usually not covered yet by dental insurance. The fee for this exam is ***20 dollars***. Please sign below in the appropriate spot to accept or decline treatment. Once again, we feel this breakthrough technology is important and in the long run save lives.

YES.

I AUTHORIZE THE DOCTORS AND OR THE HYGIENEST TO PERFORM THE VELOSCOPE EXAMINATION.

Print Name _____

Signature _____ Date _____

NO.

I WOULD PREFER NOT TO HAVE THE VELOSCOPE EXAMINATION AT THIS TIME

Print Name _____

Signature _____ Date _____

Ron Kaminer | D.D.S.

1315A Broadway, Hewlett, NY 11557 | Tel. 516.239.6204 | Fax. 516.706.2836 | www.nylaserdentistry.com

CONSENT FOR TREATMENT

WHO CAN WE SPEAK TO WITH REGARDS TO YOUR TREATMENT IF NEEDED?

NAME _____ RELATIONSHIP _____

- I HEREBY CONSENT TO DR. KAMINER/ HYGIENEST /ASSOCIATE DOCTORS TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, AND ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DOCTORS TO MAKE A THOROUGH DIAGNOSIS OF (NAME OF PATIENT) _____'S DENTAL NEEDS.

- I AUTHORIZE DOCTOR TO PREFORM ALL RECOMMENDED TREATMENT MUTUALLY AGREED UPON BY ME AND TO EMPLOY SUCH ASSISTANCE AS REQUIRED PROVIDING PROPER CARE.
- I AGREE TO THE USE OF ANESTHETICS, SEDATIVES & OTHER MEDICATIONS AS NECESSARY. I UNDERSTAND THAT THE MENTIONED AGENTS EMBODIES CERTAIN RISKS AND I CAN ASK FOR A COMPLETE RECITAL OF ANY POSSIBLE COMPLICATIONS.
- I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENEDERED ON MY BEHALF OR MY DEPENDENTS. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE. ALL SALES ARE FINAL.
- PLEASE SIGN BELOW

PATIENT _____ DATE _____

PARENT OR RESPONSIBLE PARTY _____