SJ Family Dental
35a Guy Lombardo Ave
Freeport, NY 11520

Date:_____

Name: _____ _____
First Last

Sex: ☐ Male ☐ Female

Date of birth : ____/____/____ Age:_____

Social Security : ____/_____/_____

Home Address :_____

_____
City State Zip-code

☐ Single ☐Married ☐Divorced/Separated ☐Widowed

Home phone# (___)_____ Cell #(____)_____

Work phone#(____)_____ Other( )-_____

EMAIL:_____

Spouse Information

Name :_____ _____ _____
First Last

home phone# __(___)_____ Cell #(____)_____

Insurance

Dental Coverage ☐ Yes ☐ No

Insurance Address:_____

_____

Insurance phone #( )_____

Insured's Name_____
First Last

Date of birth:____/_____/_____

Social security #_____/_____/____

Insured's employer:_____

Insured's address:_____

Phone ( ) _____

ID# _____

Group #_____

Maximum: $ _____ Deductible $ _____

Major ____% Basic____%
Prev_____%

How did you hear of us ?_____

Important

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature_____ Date:_____

Medical History

Did you have a personal Physician? Yes No

Physician Name:_____

Phone:_____

Date of the last visit_____
Your current physical health is: Good Fair Poor

Are you currently under the care of a physical_____

Are you taken any medications: Yes___ No___
If Yes please write them here: _____
_____

Have you ever had any of the following diseases or medical problems?

Yes No Abnormal Bleeding
Yes No Aids
Yes No Alcohol/ Drug Abuse
yes No Anemia
yes No Arthritis
yes No Asthma
yes No Blood Transfusion
yes No Cancer
yes No Colitis
yes No Diabetis
yes No Difficulty breathing
yes No Epilepsy
yes No Glaucoma
yes No Heart attack/ surgery
yes No Hepatitis
yes No Herpes
yes No High blood pressure
yes No HIV
yes No Kidney Problems
yes No Liver Disease
yes No Low blood pressure'
yes No Lupus
yes No Psychiatric problems
yes No Stroke
yes No Thyroid
yes No Tuberculosis
yes No Ulcers
yes No Venereal Disease

Are you Allergic to any of the Following?

Y N Aspirin Y N Erythromycin Y N Latex
Y N Codeine Y N Jewelry/Metals Y N Penicillin
Y N Tetracycline Y N Dental Anesthetics

Dental History

Why have you come to the dentist today ?
_____

Are you currently in pain?_____
Do you require antibiotics before dental Treatment?_____

Your current dental health is :
Good Fair Poor
Are you Pregnant?_____
If yes week # _____
Are you Nursing _____

Do you Floss Daily?_____
Do your gums ever Bleed?_____
Have you ever had gum Treatment?_____

I understand that the information that I have given today is correct to the best of My knowledge. I also understand that this Information will be held in the strictest Confidence and it is my responsibility to Inform this office of any changes in my Medical status and personal information. I authorize the dental staff to perform any Necessary dental services that I may need During diagnosis and treatment, with my Informed consent.

_____ _____
Signature Date.