*MEDICAL HISTORY****** (REVIEW)___ ___ ___ ___ ___ ___ ___ ___ ___

Physician's Name?_____ City/phone #_____

How long ago was your last medical physical exam?____ Years _____Months

Are there any Issues you would like to discuss with the Doctor or Staff?_____

DO *YOU HAVE OR HAD ANY OF THE FOLLOWING CONDITIONS*?

□Are you under any medical treatment now? For what?_____

□Had any serious hospitalization within 5 years? For what?_____

□Are you taking any medications including non-prescription medicine? LIST:

_____

_____

□Are you allergic to or have you had any reaction to the following:

□Penicillin □Erythromycin □Sulfa □Aspirin □Latex □Codeine □Metal(Nickel, Mercury, Gold)

□Sedatives □Any other allergies?_____

What reaction did you have?_____

WOMEN:ARE YOU: □PREGNANT(How many months?_____) □NURSING □TAKING BIRTH CONTOL PILLS?

ARE THERE ANY OTHER MEDICAL ISSUES WE SHOULD KNOW ABOUT?_____

Do you have or have had any of the following?			Take Meds?- Circle for which conditions	
□High Blood Pressure	□Heart Disease	□Heart Attack	□Stroke	□Diabetes
□Anemia	□Cancer_____	□Seizures	□Epilepsy	□ Eating Disorders
□Mitral Valve Prolapse	□Rheumatic fever	□Thyroid problems	□Aids/HIV	□Pacemaker
□Artificial Valves or Joints	□Ulcers	□Fainting/Low BP	□Arthritis	□Blood disease
□Heart Murmur	□Asthma	□Glaucoma	□Chest pain	□Angina
□Swollen Ankles	□Emphysema	□Hay Fever	□Severe Headaches	□Kidney Disease
□Radiation Therapy	□Constant fever	□Night Sweats	□Stomach Reflux	□Tuberculosis
□Hepatitis A B C /Liver Disease	□Excessive Bleeding	□Severe Weight Loss	□Sinus Problem	□Panic Attacks
□Venereal Disease	□Chemical Dependency	□Drugs for Depression	□Anxiety	□Dry Mouth

DENTAL HISTORY

ARE THERE ANY DENTAL ISSUES YOU HAVE QUESTIONS ABOUT?_____

Do you wear: □Dentures □Partial dentures (How old are they?_____) □Implants □Braces □Mouthguard

Do you have an interested in? □ Implants? □Cosmetic Dentistry? □Whitening? □Replacements?

HAVE YOU HAD INJURY TO YOUR: □Jaw □Head □Neck □Cheek □Tongue □Teeth which ones?_____

HAVE YOU HAD: □Orthodontics □Periodontal Treatment □Wisdom Teeth □ Teeth Extracted □Bleaching

DO YOU FEEL PAIN IN: □Teeth(which ones?_____) □Gums □Tongue □When chewing □Ear □Jaw?

DO YOU: □Bite Lip or Cheeks Have□Loose Teeth □Bleeding Gums □Sore Gums □Use Tobacco? □Smoke?

□Have Sores, Blisters or Lumps □in or □near your Mouth? □Clench or Grind? □Suck your Thumb?

□Mouth Breath? □Catch Food □Have Sensitivity to Cold or □Hot? □An Unpleasant Taste/Breath?

□Clicking or Popping Noise near your Ears? □Tetracycline Staining? □Have Extra Teeth?

DENTAL HISTORY-NEW PATIENT SECTION

Name of Previous Dentist_____ Location_____ Tel #_____

How long ago was your Last Exam/Cleaning?____ X-Rays?(Good for 1 yr)____ Full Mouth X-Rays?(good for 5 yrs)___

Please have your X-rays mailed or emailed to us . A Release form and copying fee are usually required by dental offices for the transfer of X-rays

DO YOU LIKE YOUR SMILE?_____ If not why?_____

Have you had difficulty with dental visits? □Yes □No If yes, what?_____

How often do you brush? ____ Are you using a soft/med or hard brush?_____ Soft is recommended

Do you use □Floss □Fluoride Rinses □Fluoride Supplements □Prevident 5000 □Bridge Cleaners □Whitestrips □Bleaching □Whitening Toothpaste □Mouthwash □Interdental Cleaners?

Office use: I have made a good faith effort to obtain the individual's signature on this form. If they would not sign why?_____ XX_____ date_____

WELCOME–Thank you for choosing our practice for your dental needs. Drs. Ginsberg & Staff

PLEASE FILL OUT BOTH SIDES OF THIS FORM AND SIGN BELOW TODAY'S DATE_____

NAME_____ BIRTHDATE_____ SEX ☐M ☐F

SOCIAL SECURITY#_____ ADDRESS_____

CITY_____ ST_____ ZIP_____ E-MAIL ADDRESS_____@_____

TELEPHONE# HOME_____ WORK_____ CELL_____

FAX#_____ EMPLOYER_____ CITY_____ Occupation_____

SPOUSE/INSURED☐'S NAME/WORK #_____

WHERE CAN WE CONTACT YOU: ☐Home ☐Work ☐Cell ☐Email SPOUSE OR INSURED'S SS#_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____ PHONE#_____

PURPOSE OF TODAY'S VISIT: ☐Checkup ☐Cleaning ☐Pain ☐Problem?_____

ARE YOU A: __MINOR __SINGLE __STUDENT __MARRIED __DIVORCED __WIDOWED __SEPARATED __PARTNER

Whom in your family is a patient?_____ ☐ First member of family

If you are a STUDENT 18+: SCHOOL NAME & CITY_____ Full time? ☐Y ☐N

IF UNDER 18: RESPONSIBLE PARTY?_____ RELATIONSHIP?_____

SS#(If different)?_____Their Address?_____ WHO MAKES APPTS?_____

WORK OR CELL #_____ EMPLOYER?_____

I AUTHORIZE DENTAL SERVICES, X-RAYS AND USE OF ANESTHETICS FOR THIS PATIENT.I HAVE ACCESS TO THE NOTICE OF PRIVACY PRACTICES.

XX_____(SIGNATURE OF RESPONSIBLE PARTY)

Why did you choose our office? ☐Friend/Family ☐Phone Book/Ad ☐Insurance ☐Internet ☐Other_____

May we thank anyone for the referral?_____

WHAT METHOD OF PAYMENT DO YOU PREFER FOR PAYMENT, DEDUCTIBLE AND/OR CO-PAYMENT?

Please check one: ☐CASH ☐CHECK ☐VISA ☐MC ☐AE ☐ DISCOVER ☐ CARE CREDIT ☐FLEXI-PLAN

**********INSURANCE INFORMATION (Please Present Insurance Card)**********

INS.CO._____GROUP &/OR EMPLOYER_____

☐PPO ☐DMO ☐PREMIER ☐PREFERRED ☐OPTION PLUS Maximum $$?_____

NAME OF INSURED (If not the pt)_____ POLICY#_____

RELATIONSHIP TO PATIENT_____ INSURED'S BIRTHDATE_____

OTHER INSURANCE CO./GP #/POLICY #_____

☐ ADD'L INS. POLICYHOLDER/BIRTHDATE_____

Deductible & Co-payments are due at time of service. (If not known, the average of $50 deductible and 20% co-payment will be used)

Your deductible?_____ Your co-payment %?_____

AUTHORIZATION,RELEASE, AND AGREEMENT TO PAY FOR SERVICES RENDERED

**I attest that the information on both sides of this form is accurate and complete to the best of my knowledge. I understand that it is my responsibility to inform my doctor if I, or a minor child, ever have a change in information. I hold no one responsible for errors or omissions I have made. I authorize disclosure of this information to health practitioners and/or my insurance company(s) for the purpose of obtaining payment for services and determining benefits.

**I am aware that there is a fee if I cancel within 24 hour of a scheduled appointment.

**I acknowledge that payment is due(including deductible and co-payments determined by my policy)at the time of treatment unless other arrangements are made prior to appointment. I agree that parents/guardians signing this form are financial responsible for all fees and services rendered to a minor.

**I acknowledge that I have received a Notice of Privacy Practices from the above named practice. (On clipboard)

**Insurance: I assign directly to Dr. Ginsberg all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financial responsible for all charges whether or not paid by insurance.

PLEASE SIGN BELOW:

XXXX_____ Date_____