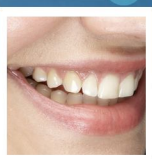
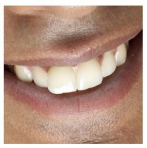
Dentistry on Broadway
133 Broadway
Lynbrook, NY 11563

(516)825-8009
dentistryonbroadway@yahoo.com
www.dentistryonbroadway.com





Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Are you currently taking any prescription or non-prescription medications?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (contacts or glasses)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

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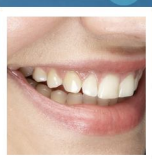

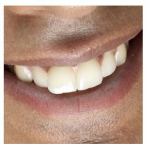

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

Please indicate if you have experienced any of the following:

☐ Abnormal Bleeding	☐ AIDS/HIV	☐ Allergic Aspirin
☐ Allergic Codine	☐ Allergic Epinephrine	☐ Allergic Erythromyci
☐ Allergic LATEX	☐ Allergic Penicillin	☐ Allergic Sulfur
☐ Allergic To Anesthet	☐ Allergic Zithromisin	☐ Allergies
☐ Allg. Amoxicillin	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asthma/ Bronchitis	☐ Autoimmune Disease
☐ Birth Control	☐ Blood Disease	☐ Blood thinners
☐ Blood Transfusion	☐ Cancer	☐ Cardiovascular
☐ Damaged heart valves	☐ Diabetes	☐ Dizziness
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting
☐ G.E Reflux	☐ Glaucoma	☐ Heart Disease
☐ Heart Murmur	☐ Hemophilia	☐ Hepatitis
☐ High Blood Pressure	☐ Hip Replacement	☐ Jaundice
☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure
☐ Mental Disorders	☐ Mitro Valve Prolapse	☐ Nervous Disorders
☐ Other	☐ Pacemaker	☐ Parkinsons
☐ Pregnancy	☐ Premedicate	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Seizures	☐ Sinus Problems	☐ Stroke
☐ Systemic Lupus	☐ Thyroid	☐ Tuberculosis

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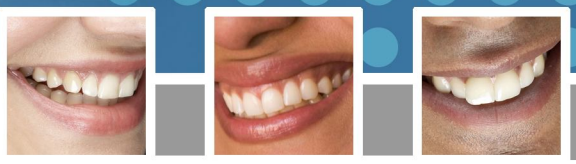

☐ Tumors ☐ Ulcers ☐ Venereal Disease

Do you have any other health issues or allergies?

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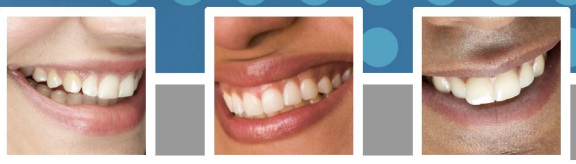

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

○ 1 (+) a day ○ 2 - 6 weekly ○ 1 - 6 monthly ○ Seldom ○ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

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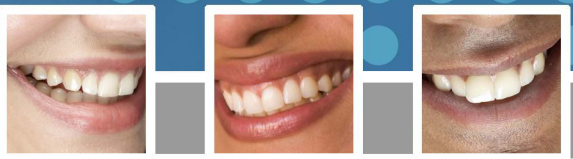

If you could change anything about your mouth, teeth, or smile, what would it be?

* ☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date:*

Relationship to Patient:

Electronic Signature:

Response Date:

***Please fill out and save the form, and email it to Dobpatients@gmail.com**