HORSEHEADS DENTAL

Helping People Help Themselves
Through Prevention and Education

2898 Westinghouse Road, Suite 524
Horseheads, NY 14845
(607) 739-3528
www.HorseheadsDental.com

PERSONAL INFORMATION

ADULT PATIENTS

Date _____

Name _____ Jr., Sr., III Age _____ Birthdate _____ Gender ____
Last First Middle initial(s)

Nickname _____Marital status: □ Married □ Single □ Widowed □ Divorced SS# _____

Mailing address _____
Street Apt. # City State ZIP

Home address
if different _____ Phone (___)_____ Occupation _____

Employer _____ Spouse's name _____

Business address _____Business address _____
Street Street
(____)_____ (____)_____
Phone City State ZIP Phone City State ZIP

CHILD AND ADOLESCENT PATIENTS

Date _____

Name _____ Jr., III Age _____ Birthdate _____ Gender ____
Last First Middle initial(s)

Mailing address _____(___)_____
Street City State ZIP Phone

Mother's name _____

Father's name _____

Home address
if different _____(___)_____
Phone

Home address
if different _____(___)_____
Phone

GETTING TO KNOW YOU

Person to contact for emergency _____ Jr., Sr., III Relationship _____
Last First Middle initial(s)

Home address _____(___)_____
Street City State ZIP Phone

Whom may we thank for referring you to our office? _____

Has any member of your family ever been treated in our office? □ Yes □ No

If so, who? _____

Is there anything special you would like us to know about you? _____

_____

Any special hobbies or interests you would like to talk about? _____

_____

HORSEHEADS DENTAL

Helping People Help Themselves
Through Prevention and Education

2898 Westinghouse Road, Suite 524
Horseheads, NY 14845
(607) 739-3528
www.HorseheadsDental.com

MEDICAL HEALTH HISTORY

How would you describe your general health? □ Excellent □ Good □ Fair □ Poor
Are you under the care of a physician? □ Yes □ No (If yes, please explain)

_____

_____

Physician's
Name_____Address_____(___)_____
Phone

Family physician's
Name_____Address_____(___)_____
Phone

Have you ever been hospitalized or had a major operation? □ Yes □ No Discuss
Have you ever had a serious injury to your head or neck? □ Yes □ No Discuss
Are you taking any medications, pills or drugs? □ Yes □ No What?
Do you now have or have you ever had any of the following? Please circle all that apply.

*If any of the asterisked conditions apply, please call prior to your appointments. Premedication may be required.

Heart trouble/disease	Bruise easily	Emphysema	Yellow jaundice	Cold sores
Heart murmur*	Anemia	Tuberculosis	Kidney problems	Fever blisters
Irregular heart beat	Excessive bleeding	Cancer	Renal dialysis	Herpes
Angina/chest pain	Sickle cell disease	X-ray treatments (radiation)	Thyroid disease	Stroke
Heart attack/failure	Hemophilia (bleeding problems)	Chemotherapy	Parathyroid disease	Convulsions
Congenital heart disorder	Leukemia	Stomach/intestinal disease	Arthritis/gout	Epilepsy or seizures
Mitral valve prolapse*	Recent blood transfusion	Ulcers	Rheumatism	Fainting or dizziness
Scarlet fever	Swelling of limbs	Recent weight loss	Pain in jaw joints	Glaucoma
Rheumatic fever*	Lung disease	Frequent diarrhea	Cortisone medicine	Tumors or growths
Artificial heart valve*	Breathing problem	Diabetes	Artificial joint*	Nervousness
Heart pace maker*	Shortness of breath	Excessive thirst	Venereal disease	Psychiatric care
Heart surgery*	Frequent cough	Hypoglycemia	AIDS	Alzheimer's disease
High blood pressure	Hay fever	Liver disease	HIV positive	Allergies (medicine)
Low blood pressure	Sinus trouble	Hepatitis A	Genital herpes	Allergies (pollen/dust)
Blood disease	Asthma	Hepatitis B or C	Osteoporosis	Hives or rash

Have you ever had any other serious illness not listed above? □ Yes □ No Discuss_____
Have you ever had to take any medications before your dental appointment? □ Yes □ No _____
Are you allergic or sensitive to any of the following medications? Please circle all that apply.

Penicillins	Aspirin	Lidocaine	Novocaine
Erythromycins	Tylenol	Xylocaine	Valium
Tetracyclines	Codeine	Carbocaine	Latex

List other medications you are allergic or sensitive to_____
Do you smoke? □ Yes □ No How long?_____Number of packs per day_____
For women, are you: □ Pregnant/trying to get pregnant? Delivery date?
□ Taking birth control pills?
□ Taking hormone replacement medications?

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications changes, I shall inform the dentist and staff at the next appointment without fail.

_____ _____

Signature of: □ Adult patient □ Father □ Mother □ Spouse □ Partner □ Guardian Date

HORSEHEADS DENTAL

Helping People Help Themselves
Through Prevention and Education

2898 Westinghouse Road, Suite 524
Horseheads, NY 14845
(607) 739-3528
www.HorseheadsDental.com

DENTAL HEALTH HISTORY

Are you now in discomfort requiring immediate attention? □ Yes □ No (If yes, please explain)

_____

_____

Former dentist_____How long?_____Date of last visit_____

Have you ever had any serious trouble associated with previous dentistry? □ Yes □ No
Does dental treatment make you nervous? □ No □ Slightly □ Extremely
Have you ever been treated for periodontal disease
(gum disease, pyorrhea, trench mouth)? □ Yes □ No
How many times do you brush each day?_____ Brush is □ Soft □ Medium □ Firm
Do you have or have you ever had any of the following? Please circle all that apply.

Bleeding, sore gums	Biting cheeks/lips	Food catch/wedge between teeth
Unpleasant taste/bad breath	Loose teeth	Gum treatment
Burning tongue/lips	Sensitive to hot	Oral surgery
Frequent blisters, lips/mouth	Sensitive to cold	Bite treatments
Swelling/lumps in mouth	Sensitive to sweets	Root canal treatments
Ortho treatments (braces)	Sensitive to biting	Chronic neck or ear pain

Do you use the following?

Brush (circle: manual or electric?)	□ Yes	□ No
Fluoride rinse	□ Yes	□ No
Dental floss	□ Yes	□ No
Other_____		

These are the things that are important to me about my dental health:_____
_____
_____
_____
_____

What do you fear most about dental care?
_____
_____
_____
_____

What are some questions about dentistry and oral health that you have never had adequately answered?
_____
_____
_____
_____
_____

Circle one:

- My mouth is a) very uncomfortable.
  b) moderately uncomfortable.
  c) uncomfortable.
- I a) think the appearance of my mouth is excellent.
  b) am satisfied with the appearance of my mouth.
  c) am dissatisfied with the appearance of my mouth.
- I a) will do anything to keep my natural teeth.
  b) want to keep my teeth, but have a certain budget of time and money I'm willing to spend on them.
- I a) have set goals for my oral health with a previous dentist.
  b) want to set goals concerning my dental health.
- I a) have always tried to do the best that was recommended for my dental health.
  b) have not done what dentists have recommended.
  c) rarely go and don't care much about having any dental work completed.
- I have put dentistry for myself and my family:
  a) high on my priority list.
  b) low on my priority list.
  c) on my list, but it's hard to find.
- I think my present state of dental health is:
  a) excellent. b) good. c) poor.
- I aspire to have a mouth in:
  a) excellent health. b) good health. c) poor health.

HORSEHEADS DENTAL

Helping People Help Themselves
Through Prevention and Education

2898 Westinghouse Road, Suite 524
Horseheads, NY 14845
(607) 739-3528
www.HorseheadsDental.com

SCREENING HISTORY FOR TEMPOROMANDIBULAR JOINT DISORDER

Do you have difficulty opening your mouth? □ Yes □ No

Do you hear noises from the jaw joints? □ Yes □ No

Does your jaw get "stuck," "locked" or "go out"? □ Yes □ No

Do you have pain in or about the ears or cheeks? □ Yes □ No

Do you have pain when chewing, yawning or opening wide? □ Yes □ No

Does your bite feel uncomfortable or unusual? □ Yes □ No

Do you clench or grind your teeth? □ Yes □ No

Have you ever had an injury to your jaw, head or neck? □ Yes □ No

Have you ever had arthritis? □ Yes □ No

Have you been treated for a temporomandibular joint disorder? □ Yes □ No

If so, when, what, how and by whom?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Signature of patient, parent or legal guardian Date

HORSEHEADS DENTAL

Helping People Help Themselves
Through Prevention and Education

2898 Westinghouse Road, Suite 524
Horseheads, NY 14845
(607) 739-3528
www.HorseheadsDental.com

ACCOUNT INFORMATION

Name of person responsible for payment_____Relationship to patient_____
Last First Middle

Mailing address_____(___)_____
Street City State ZIP Phone

Employer_____Occupation_____SS#_____

Business address_____(___)_____
Street City State ZIP Phone

Primary dental insurance carrier company_____

Employee_____ Group#_____

Birthdate_____SS#_____

Employer_____

Business address_____(___)_____
Street City State ZIP Phone

Secondary dental insurance carrier company_____

Employee_____ Group#_____

Birthdate_____SS#_____

Employer_____

Business address_____(___)_____
Street City State ZIP Phone

METHOD OF PAYMENT

All charges of $_____ or less are to be paid in full at time of service (cash, personal check, MasterCard, Visa).

□ I wish to pay in full at each visit (cash, check or credit card).

□ I wish to discuss the office's financial policy.

SERVICE CHARGE

If I do not pay the entire new balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period.

The service charge will be a periodic rate of 1.5% per month, which is an annual percentage rate of 18% unless involved with a financial arrangement, in which the finance charge will be waived.

ACKNOWLEDGMENT

I understand that I am responsible for all costs of dental treatment. I hereby authorize Warren E. Eng, D.D.S., F.A.G.D. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

The information on this page is correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third-party payers and/or other health professionals.

_____ _____

Signature of: □ Adult patient □ Father □ Mother □ Spouse □ Partner □ Guardian Date

HORSEHEADS DENTAL

Helping People Help Themselves
Through Prevention and Education

2898 Westinghouse Road, Suite 524
Horseheads, NY 14845
(607) 739-3528
www.HorseheadsDental.com

CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION

Patient's name_____Date of birth_____

SS#_____

Dentist: Warren E. Eng, D.D.S., F.A.G.D.

My personal health information is private and confidential. I understand that my dentist and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my dentist and his staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information. I understand that sometimes the law may require the release of this information without my permission.

I can ask my dentist to limit how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that my dentist does not have to agree to my request. If my dentist does agree to my request, I understand that my dentist and his staff would follow the agreed limits.

I may cancel this consent at any time by doing the following:

> Writing, signing and dating a letter to my dentist revoking permission to disclose health information. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment and health care operations.

If I cancel this consent, my dentist and his staff do not have to provide any further health care services to me.

My dentist has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the document before signing this agreement. If I ask, my dentist or his staff will provide me with the most current Notice of Privacy Practices, which also is posted at my dentist's office.

My signature below indicates that I have been given the opportunity to review a current copy of my dentist's Notice of Privacy Practices. My signature means that I agree to allow my dentist to use and disclose my personal health information to carry out treatment, payment and health care operations.

_____ _____

Patient's or legally authorized individual's signature Date

_____

Relationship to patient