laserdentalcare

Laserdentalcare
115 Central Park West
New York, NY 10023
www.alangoldsteindentist.com

Patient

Today's Date / / E-mail Address

Name I prefer to be called Male ☐ Female ☐

Last First MI Mr. Mrs. Ms. Dr.

Birthdate / / Age Social Security No.

Home Address

Street Apt # City State Zip

Home Phone ( ) Mobile ( ) Work Phone ( ) Ext.

Where & when are best times to reach you? Whom may we thank for referring you?

Other family members seen by us

Employer How long there? Occupation

Employer Address

Street/PO box City State Zip

Emergency Contact

(Neighbor or Relative not living with you)

His/Her Name Relation Work Phone ( ) Home Phone ( )

Address

Street Apt # City State Zip

Insurance Information

Primary Insurance Dental Coverage? Yes ☐ No ☐ Orthodontic Coverage? Yes ☐ No ☐ Medical Coverage? Yes ☐ No ☐

Insurance Co. Name Phone ( ) Group No. (Plan, Local or Policy No.)

Insurance Co. Address

Street/PO box City State Zip

Insured's Name (If not patient) Insured's Social Security No. Insured's Birthdate / / Relation

Insured's Employer Employer's Address

Street/PO box City State Zip

Secondary Insurance Dental Coverage? Yes ☐ No ☐ Orthodontic Coverage? Yes ☐ No ☐ Medical Coverage? Yes ☐ No ☐

Insurance Co. Name Phone ( ) Group No. (Plan, Local or Policy No.)

Insurance Co. Address

Street/PO box City State Zip.

Insured's Name (If not patient) Insured's Social Security No. Insured's Birthdate / / Relation

Insured's Employer Employer's Address

Street/PO box City State Zip

Dental History

Why have you come to the dentist today? ______________________

____

Are you currently in pain? Yes ☐ No ☐
Do you require antibiotics before dental treatment? Yes ☐ No ☐
Your current dental health is: Good ☐ Fair ☐ Poor ☐
Do you floss daily? Yes ☐ No ☐ Brush daily? Yes ☐ No ☐
Type of bristles on your toothbrush? Hard ☐ Medium ☐ Soft ☐
Do your gums ever bleed? Yes ☐ No ☐

Are your teeth sensitive to heat, cold or anything else? ______________________
Do your teeth move? Yes ☐ No ☐
Do you still have wisdom teeth? Yes ☐ No ☐
Previous/Present Dentist ______________ Last Visit Date ______________
(Please Circle)
Would you like fresher breath? Yes ☐ No ☐ Whiter teeth? Yes ☐ No ☐
Are you happy with the way your smile looks? Yes ☐ No ☐
If not, what would you change? ______________________

____

Medical History

Do you have a personal physician? Yes ☐ No ☐

Physician's Name ______________________

Address ______________________
Street State Zip

Phone ( ) ______________ Date of last visit ______________

Your current physical health is: Good ☐ Fair ☐ Poor ☐

Do you smoke or use tobacco in any other form? Yes ☐ No ☐

For Women: Are you taking birth control pills? Yes ☐ No ☐
Are you pregnant? Unsure ☐ Yes ☐ No ☐
Week # ______________
Are you nursing? Yes ☐ No ☐

Do you or have you experienced the following? (Please Circle)

Abnormal bleeding	Y	N	Colitis/Ileitis	Y	N	Headaches	Y	N	Low Blood Pressure	Y	N	Sickle Cell Disease	Y	N
Alcohol Abuse	Y	N	Congenital Heart Defect	Y	N	Heart Attack	Y	N	Lupus	Y	N	Sinus Problems	Y	N
Anemia	Y	N	Diabetes	Y	N	Heart Murmur	Y	N	Mitral Valve Prolapse	Y	N	Steroid Therapy	Y	N
Arthritis	Y	N	Difficulty Breathing	Y	N	Heart Surgery	Y	N	Pacemaker	Y	N	Stroke	Y	N
Artificial Bones/Joints	Y	N	Drug Abuse	Y	N	Hemophilia	Y	N	Persistent Cough	Y	N	Thyroid Problems	Y	N
Artificial valves	Y	N	Emphysema	Y	N	Hepatitis	Y	N	Psychiatric Problems	Y	N	Tonsillitis	Y	N
Asthma	Y	N	Epilepsy	Y	N	Herpes	Y	N	Radiation Treatment	Y	N	Tuberculosis (TB)	Y	N
Blood Transfusion	Y	N	Fainting spells	Y	N	High Blood Pressure	Y	N	Rheumatic Fever	Y	N	Ulcers	Y	N
Cancer	Y	N	Fever Blisters	Y	N	HIV+/AIDS	Y	N	Scarlet Fever	Y	N	Venereal Disease	Y	N
Chemotherapy	Y	N	Glaucoma	Y	N	Kidney Problems	Y	N	Seizures	Y	N			
Chicken Pox	Y	N	Hay Fever	Y	N	Liver Disease	Y	N	Shingles	Y	N			

Please list any serious medical condition(s) that you have experienced ______________________

Have you ever been hospitalized? Yes ☐ No ☐ If yes, please list each one ______________________

____

Are you taking any prescription / over the counter drugs? Yes ☐ No ☐ If yes, please list each one ______________________

____

Have you ever taken Phen-Fen, Redux or Pondimin? Yes ☐ No ☐ If yes, please list each one ______________________

____

Are you allergic to any of the following? (Please Circle)

Aspirin	Y	N	Codeine	Y	N	Erythromycin	Y	N	Latex	Y	N	Sedatives	Y	N	Tetracycline	Y	N
Barbiturates	Y	N	Dental Anesthetics	Y	N	Jewelry / Metals	Y	N	Penicillin	Y	N	Sulfa Drugs	Y	N	Other	Y	N

Please list any additional medications to which you believe you are allergic ______________________

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

Patients Signature ______________________ Date

Doctor's Signature ______________________ Date

Authorization

I authorize dental staff to perform any services that I many need. I understand that I am responsible for payment of services rendered, including charges not covered by dental insurance.

Signature ______________________ Date ______________

Please note: Our office policy is that 2 business days' notice (excluding weekends) is required for cancellations. There is a charge for broken appointments.