R.J. MOLINARI, D.D.S • S. HERSHENHORN, D.D.S. • S. BLUM, D.D.S. • O. ZUSIN, D.D.S.
100 Manetto Hill Road • Plainview, New York 11803 • (516) 935-0670

REGISTRATION AND HEALTH HISTORY

NAME _____ SINGLE MARRIED DIVORCED SEPARATED WIDOWED

RESIDENCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ AGE _____ HOME PHONE _____ YOUR SOCIAL SECURITY NO. _____

EMPLOYED BY _____ CITY _____ STATE _____ BUS. PHONE _____

PRESENT POSITION _____ HOW LONG HELD _____

NAME OF SPOUSE _____ BIRTH DATE _____ SPOUSE'S SOCIAL SECURITY NUMBER _____

SPOUSE EMPLOYED BY _____ CITY _____ STATE _____ BUS. PHONE _____

PRESENT POSITION _____

REFERRED BY _____ ADDRESS _____

WHO WILL PAY FOR THIS ACCOUNT? _____

NAME OF YOUR DENTAL INSURANCE COMPANY _____ SPOUSAL OR SECOND INSURANCE _____

It is important that we know about your dental and medical history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you in detail. Information you give us is strictly confidential and will not be released to anyone without your written permission.

PURPOSE OF THIS APPOINTMENT _____

DENTAL HISTORY

	Yes	No
Are you having any discomfort at this time?	___	___
Have you had dental x-rays within the last year?	___	___
Do you visit the dentist every 6 months	___	___
Were you formally taught oral hygiene?	___	___
Have there been any injuries to your teeth?	___	___
Are any teeth loose?	___	___
Have you lost any teeth?	___	___
Do you want to replace any missing teeth?	___	___
Have you had any complications with extractions	___	___
Do you have any bridgework?	___	___
Are your teeth sensitive to cold	___	___
to sweets	___	___
to heat	___	___
Have you had your teeth straightened?	___	___
Do you have bleeding gums?	___	___
Do you have a breath problem?	___	___
Have you ever had gum treatments?	___	___

	Yes	No
Does food wedge between your teeth?	___	___
Do you grind or clench your teeth?	___	___
Do you have pain in the jaws upon waking?	___	___
Any pain in or around your ears?	___	___
Do you hear popping, clicking or snapping noises when you chew?	___	___
Do you have any nasal obstruction?	___	___
Are you aware of any swelling or lump in your mouth?	___	___
Do you now have or have you had any of the following habits:		
Chewing Gum ___	___	___
Sucking Candy ___	___	___
Smoking ___	___	___
Do you have any fear of having dentistry done?	___	___
Do you prefer anesthesia by injection?	___	___
Do you require nitrous oxide (gas) for dental work?	___	___
Do you prefer no anesthesia when possible?	___	___

Name of last dentist _____

Why did you leave your last dentist _____ Last seen on: _____

Other Side, Please.

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM _____

ADDRESS _____ TELEPHONE # _____

SIGNATURE FOR THE RELEASE OF MEDICAL AND DENTAL RECORDS, WHEN NECESSARY

Date _____ Your Signature _____

Do you have or have you had any of the following. Please indicate with check mark (✓).

___ Any heart problems
___ High blood pressure
___ Low blood pressure
___ Circulatory problems
___ Nervous problems
___ Radiation treatments
___ Excessive bleeding
___ Prolapsed Mitral Valve
Are you pregnant _____

___ Allergy to Penicillin
___ Allergies to anesthetics
___ Allergies to medicines or drugs
___ Allergies to _____
___ Anemia
___ Arthritis
___ Asthma
Blood Pressure: S___ / D ___ /

___ Diabetes
___ Hepatitis A ___ B ___
___ Malignancies
___ Measles
___ Mumps
___ Psychiatric care
___ Rheumatic Fever
___ Heart Murmer

___ Scarlet Fever
___ Sinus Problems
___ Stroke
___ Typhoid Fever
___ Tonsilitis
___ Tuberculosis
___ Ulcer
___ Veneral Disease
___ H.I.V.

Specialist's Name _____ Address _____ Phone _____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.

_____

_____

Person to notify in case of emergency: _____

THIS INFORMATION WAS GIVEN BY _____ DATE _____

FOR OFFICE USE ONLY

DATE	SERVICES	CHARGES	CREDITS	BALANCE

Island Dental Group
100 Manetto Hill Rd., Ste 211
Plainview, NY 11803
(516) 935-0670

Date: _____

Medical History

Name: _____ Date of Birth:_____

Address:_____

_____

Phone: _____ Cell: _____
Email Address: _____

Dental Insurance: _____

Pharmacy: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Do you have any allergies? Please list: _____

_____

Medical Updates: _____

_____

_____

Current medications: _____

_____