PREMIER ENDODONTICS OF LONG ISLAND

PATIENT INFORMATION

LAST NAME | FIRST NAME | INITIAL | DATE

SOCIAL SECURITY NO. | BIRTHDATE

ADDRESS | CITY | STATE | ZIP

HOME PHONE | MOBILE PHONE | EMAIL ADDRESS

SEX ◯ Male ◯ Female ◯ Minor ◯ Single ◯ Married ◯ Long-Term Partner ◯ Divorced ◯ Separated ◯ Widowed

EMPLOYER | OCCUPATION

EMPLOYER ADDRESS | CITY | STATE | ZIP

BUSINESS PHONE

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? | PHONE

PRIMARY INSURANCE

LAST NAME (*Person responsible for account*) | FIRST NAME | INITIAL

RELATIONSHIP TO PATIENT | SOCIAL SECURITY NO. | BIRTHDATE

ADDRESS | CITY | STATE | ZIP

HOME PHONE | INSURED EMPLOYED BY | BUSINESS PHONE

INSURANCE COMPANY

INSURANCE COMPANY ADDRESS | CITY | STATE | ZIP

SUBSCRIBER ID NO. | GROUP NO.

ADDITIONAL INSURANCE

LAST NAME (*Of insured*) | FIRST NAME | INITIAL

RELATIONSHIP TO PATIENT | SOCIAL SECURITY NO. | BIRTHDATE

ADDRESS | CITY | STATE | ZIP

HOME PHONE | INSURED EMPLOYED BY | BUSINESS PHONE

INSURANCE COMPANY

INSURANCE COMPANY ADDRESS | CITY | STATE | ZIP

SUBSCRIBER ID NO. | GROUP NO.

DENTAL HISTORY

CURRENT DENTIST | CITY | STATE | ZIP

Please check all that apply:

- ◯ Bad Breath
- ◯ Bleeding Gums
- ◯ Blisters on Lips of Mouth
- ◯ Fingernail Biting
- ◯ Grinding Teeth
- ◯ Lip or Cheek Biting
- ◯ Loose Teeth or Broken Fillings
- ◯ Orthodontic Treatment
- ◯ Pain Around Ear
- ◯ Periodontal Treatment
- ◯ Sensitivity to Cold
- ◯ Sensitivity to Heat
- ◯ Sensitivity to Sweets
- ◯ Sensitivity to Biting
- ◯ Frequent Headaches
- ◯ Jaw, Head or Neck Injuries
- ◯ Jaw Difficulty: Clicking or Pain
- ◯ Tooth Pain

MEDICAL HISTORY

PHYSICIAN'S NAME | DATE OF LAST VISIT

1. Are you currently under medical treatment? ◯ Yes ◯ No
2. Have you ever had any serious illness or operations? ◯ Yes ◯ No
3. Are you currently taking any medication? ◯ Yes ◯ No
   Please describe:
4. Do you smoke? ◯ Yes ◯ No
5. Do you use alcohol, cocaine or other drugs? ◯ Yes ◯ No
6. Do you wear contact lenses? ◯ Yes ◯ No
7. Have you had any allergic reactions to the following:

Local Anesthetics (e.g. Novocaine)	◯ Yes	◯ No
Penicillin or Other Antibiotics	◯ Yes	◯ No
Sulfa Drugs	◯ Yes	◯ No
Barbiturates (Sleeping Pills)	◯ Yes	◯ No
Sedatives	◯ Yes	◯ No
Iodine	◯ Yes	◯ No
Aspirin	◯ Yes	◯ No
Other	◯ Yes	◯ No

8. (Women Only) Are You:

Pregnant	◯ Yes	◯ No
Nursing	◯ Yes	◯ No
Taking Birth Control Pills	◯ Yes	◯ No

Have you been diagnosed with any of the following?

AIDS	◯ Yes	◯ No
Anemia	◯ Yes	◯ No
Arthritis, Rheumatism	◯ Yes	◯ No
Artificial Heart Valves	◯ Yes	◯ No
Artificial Joints	◯ Yes	◯ No
Asthma	◯ Yes	◯ No
Back Problems	◯ Yes	◯ No
Bleeding Abnormally, *with extractions or surgery*	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No
Cancer	◯ Yes	◯ No
Chemical Dependency	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No
Chronic Fatigue Syndrome	◯ Yes	◯ No
Circulatory Problems	◯ Yes	◯ No
Congenital Heart Lesions	◯ Yes	◯ No
Cortisone Treatments	◯ Yes	◯ No
Cough, Persistent or Bloody	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No
Epilepsy	◯ Yes	◯ No
Fainting or Dizziness	◯ Yes	◯ No
Glaucoma	◯ Yes	◯ No
Headaches	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No
Heart Problems	◯ Yes	◯ No
Hepatitis-Type ____	◯ Yes	◯ No
Herpes	◯ Yes	◯ No
High Blood Pressure	◯ Yes	◯ No
HIV Positive	◯ Yes	◯ No
Jaundice	◯ Yes	◯ No
Jaw Pain	◯ Yes	◯ No
Kidney Disease	◯ Yes	◯ No
Latex Sensitivity	◯ Yes	◯ No
Liver Disease	◯ Yes	◯ No
Low Blood Pressure	◯ Yes	◯ No
Mitral Valve Prolapse	◯ Yes	◯ No
Nervous Problems	◯ Yes	◯ No
Pacemaker	◯ Yes	◯ No
Psychiatric Care	◯ Yes	◯ No
Radiation Treatment	◯ Yes	◯ No
Respiratory Disease	◯ Yes	◯ No
Rheumatic Fever	◯ Yes	◯ No
Scarlet Fever	◯ Yes	◯ No
Shortness of Breath	◯ Yes	◯ No
Sinus Trouble	◯ Yes	◯ No
Skin Rash	◯ Yes	◯ No
Stroke	◯ Yes	◯ No
Swelling of Feet/Ankles	◯ Yes	◯ No
Swollen Neck Glands	◯ Yes	◯ No
Thyroid Problems	◯ Yes	◯ No
Tonsillitis	◯ Yes	◯ No
Tuberculosis	◯ Yes	◯ No
Tumor or Growth on Head/Neck	◯ Yes	◯ No
Ulcer	◯ Yes	◯ No
Venereal Disease	◯ Yes	◯ No

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Premier Endodontics of Long Island for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE OF RESPONSIBLE PARTY | DATE