Syosset Dental
Personalized Care for a Lifetime of Smiles

Dr. Kobak, Dr. Diamantakis and Dr. Raxenberg
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PATIENT INFORMATION

Date ______

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name ______ M.I. ______ Last Name ______ Nickname ______

Sex: ☐ Male ☐ Female Birth Date ______ Age ______ Soc. Sec. # ______ E-mail ______

Street ______ City ______ State ______ Zip ______

Home Tel. (______) ______ Cell. (______) ______ Have you ever been a patient of our practice? ☐ Yes ☐ No

Dentist ______ Office Tel. ______ Referred By ______

Driver's Lic.# ______ Medical Doctor/ Physicians Name: ______ Tel. (______) ______

Employer ______ Bus. Tel. (______) ______ Personal Payment Type: ☐ Cash ☐ Check ☐ Credit Card

Medical Doctor/ Physicians Name ______ Tel. (______) ______ Relation ______

Who will be responsible for your account?

(If self, skip to next section)

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other ______

Name ______ S.S.# ______ Birth Date ______ Age ______ Tel. (______) ______

Street ______ City ______ State ______ Zip ______

Employer ______ Bus. Tel. (______) ______

Spouse or other guarantor information (*if different from above*)

Name ______ Relation ______ S.S.# ______ Birth Date ______

Street ______ City ______ State ______ Zip ______

Tel. (______) ______ Employer ______ Bus. Tel. (______) ______

INSURANCE INFORMATION

Student: ☐ Full Time ☐ Part Time ☐ Not School Name/Address ______

☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ______

Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Do you belong to a PPO or HMO? ☐ Yes ☐ No

PRIMARY INSURANCE COMPANY

Insurance Type: ☐ **Dental** ☐ **Medical**

Employer ______

Bus. Address ______

Bus. Tel. (______) ______ Plan ______

Ins. Co. Name ______

Address ______

______ Tel. (______)

Group # ______ **Group Name** ______

Insured Party ______ Relation ______

Sex: ☐ M ☐ F Birth Date ______

Street ______

City, State, Zip ______

Tel. (______) ______ S.S. # ______

I.D. # ______

SECONDARY INSURANCE COMPANY

Insurance Type: ☐ **Dental** ☐ **Medical**

Employer ______

Bus. Address ______

Bus. Tel. (______) ______ Plan ______

Ins. Co. Name ______

Address ______

______ Tel. (______)

Group # ______ **Group Name** ______

Insured Party ______ Relation ______

Sex: ☐ M ☐ F Birth Date ______

Street ______

City, State, Zip ______

Tel. (______) ______ S.S. # ______

I.D. # ______

DENTAL INFORMATION

Reason for today's visit: ______ Are you in pain? ☐ Yes ☐ No, For How Long? ______

Please indicate any of the following problems by checking off the corresponding box:

☐ Discomfort, clicking, or popping in jaw
☐ Red, swollen, or bleeding gums
☐ A removable dental appliance
☐ Blisters / sores in or around the mouth
☐ Prolonged bleeding from an injury / extraction
☐ Recent infections or sore throat
☐ My teeth are sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting

☐ Lost / broken filling(s)
☐ Teeth grinding / clenching
☐ Ringing in ears
☐ Broken / chipped tooth
☐ Gum disease
☐ Dry mouth
☐ Other: ______

☐ Stained teeth
☐ Locking jaw
☐ Bad breath
☐ Burning tongue / lips
☐ Toothache
☐ Bruxisim / grinding

☐ Difficulty closing jaw
☐ Difficulty opening jaw
☐ Loose / shifting teeth
☐ Food caught between teeth
☐ Swelling / lumps in mouth
☐ Problem assc w/ teeth

Last dental exam ______ Last dental x-rays ______

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Times a day you brush? ______ Times a week you floss? ______

What type of toothbrush bristles do you use? ☐ Soft ☐ Medium ☐ Hard Would you like whiter teeth? ☐ Yes ☐ No

Is your mouth dry? ☐ Yes ☐ No Do you have bruxism or grind your teeth? ☐ Yes ☐ No Do you have issues with previous treatment? ☐ Yes ☐ No

MEDICAL HISTORY

Are you in good health? Yes No Height ____________ Weight __________ Are you under the care of a physician? Yes No

Have you had any illness, operation, or been hospitalized in the past five years? Yes No If so, describe: ______________________________

Do you have a prosthetic joint, plate or implant? Yes No If so, describe where: ______________________________

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N	
		Rheumatic fever			Are you immunosuppressed? (possibly from transplant surg.)			Hepatitis
		Mitral valve prolapse			Asthma			Infectious mononucleosis
		Heart murmur			Snoring / Sleep apnea			Fainting spells
		High blood pressure			Tuberculosis			Convulsions Epilepsy
		Low blood pressure			Emphysema			Stroke
		Chest pain / Angina			Do you smoke			Thyroid trouble
		Heart attack(s)			Blood transfusion			Diabetes
		Irregular heart beat			Blood disorder			A history of alcohol abuse
		Cardiac pacemaker			A history of drug abuse			Contagious diseases
		Heart surgery			Kidney trouble			Delay in healing
		Bronchitis / Chronic cough			Osteoporosis / Osteopenia			Anemia
		Chronic fatigue / Night sweat			Osteonecrosis			Radiation/Chemotherapy
		Mental health problems			Stomach ulcers			HIV/AIDS
		Damaged heart valves						

MEDICATION AND ALLERGIES

Are you now taking or have you taken:

Y	N		Y	N		Y	N		Y	N	
		Nerve pills			Pain killers (including aspirin)			Muscle relaxers			Antidpressants
		Tranquilizers			Insulin						
		Blood thinners (Coumadin, Aspirin, Advil)									
		Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)									

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

____

____

____

Are you allergic to or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
		Penicillin			Sulfa drugs			Local anesthetic (numbing med)			Sodium pentothal
		Valium or other tranquilizers			Aspirin			Codeine or other narcotics			Latex
								Sulfites			Amoxicillin

Please list any other medication or antibiotic you are allergic to:

____

____

Please list any allergies other than drug allergies:

____

____

1-4 below for women only: *(women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? Yes No

2) Expected delivery date: ______________

3) Are you nursing? Yes No

4) Are you taking birth control pills: Yes No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* X **Reviewed by:** X **Date:** X

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

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