



St. James Dental Care, PLLC

587 Lake Avenue, St. James, NY 11780, 631-584-5330, stjamesdentalcare.com

Name	Social Security Number	Home Phone	Cell Phone
Home Address	City, State, Zip Code		Birth Date
Marital Status	Male Female	Email Address	Drivers License Number
Primary Insurance Company		Group	Subscriber
Secondary Insurance Company		Group	Subscriber

Responsible Party

Name	Social Security Number	Home Phone	Cell Phone
Home Address	City, State, Zip Code		Birth Date
Marital Status	Relationship to Patient		Drivers License Number
Responsible Person's Employer	Occupation		Work Phone
Business Address	City, State, Zip Code		
Spouses Name	Social Security Number	Birth Date	
Spouses Employer	Spouse's Occupation		Spouse's Work Phone
Spouse's Business Address	City, State, Zip Code		

How Did You Hear About Our Office?

Friend or Family	Yellow Pages	Insurance Plan	Web Page
Advertisement	Sign on Building	Gift Card	Internet Search

If you were referred, whom may we thank for referring you?

Consent

I will answer all health questions to the best of my knowledge _____
Initial

After explanation by the doctor or dental team member, I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgment of the doctor or dental team may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and radiographs as may be deemed necessary and advisable by the doctor or dental team.

Signature **Date** **Relationship to Patient**

Terms and Conditions

This office depends on the reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.

As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental services performed without prior financial arrangements, must be paid for at the time the service is performed.

I understand dental services furnished to me are charged directly to me and that I am personally responsible for payment. I understand this office will help prepare my insurance forms and assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed _____ Date _____

There may be a charge for any missed appointments not cancelled 48 hours before the appointment time.



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Patients Dental Health

Why Have you come in to see us today?(eg:checkup, broken tooth, pain)

Previous Dentist

Last Visit

Last Cleaning

Reasons for changing dentists:

Have you had any problems with past dental treatment?

Are you nervous about seeing a dentist?

If yes, please tell us why:

How often do you brush?

How often do you floss?

Y N I clench or grind my teeth

Y N My gums feel tender or swollen

Y N My gums bleed while brushing or flossing

Y N I have problems eating

Y N I Like my Smile

Y N I would like my teeth to be straighter

Y N I have frequent headaches

Y N I have had a facial or jaw injury

Y N I avoid brushing part of my mouth due to pain

Y N I want my teeth whiter

What are your dental priorities?

Patients Medical History

Do you or have you had any of the following?

Y N Heart Disease

Y N Liver Disease

Y N Artificial Joints

Y N Congenital Heart Lesions

Y N Jaundice

Y N Immune Suppressed Disorder

Y N Stroke

Y N Hepatitis Type _____

Y N Osteoporosis or Osteopenia

Y N Rheumatic Fever

Y N Diabetes Type _____

Y N Hearing Loss

Y N Abnormal Blood Pressure

Y N Excessive Urination or Thirst

Y N Fainting Spells

Y N Anemia

Y N Arthritis

Y N Glaucoma

Y N Prolonged Bleeding Disorder

Y N Kidney Disease

Y N Asthma

Y N Tuberculosis or Lung Disease

Y N Tumor or Malignancy

Y N Seasonal Allergies

Y N Epilepsy or Seizure Disorder

Y N Cancer/Chemotherapy

Y N Sinus Problems

Y N Emotional or Nervous Disorders

Y N Radiation Treatment

Y N History Alcohol/Substance Abuse

Y N Do you smoke or use tobacco? If yes, how much per day? _____ How many years? _____

Y N Steroid Therapy (Prednisone) If yes, when? _____ For How Long? _____

Y N Bisphosphonate Therapy (Fosomax) If yes, what RX? _____ For how Long? _____

Y N Any Other Medical Problems? If yes, what? _____

WOMEN

Y N Are you taking Birth Control?

Y N Are you Pregnant or Nursing?

Are you Allergic to any of the following?

Please list all medications you are currently taking:

Y N Aspirin

Y N Ibuprofen

Y N Sulfa/Sulfites/Sulfides

Y N Penicillin

Y N Codeine

Y N Latex or Metals

Y N Local Anesthetics (Novocaine)

Y N Other: _____

Physician's Name:

Phone:

Emergency Contact:

Name:

Relationship:

Phone:

Doctor Signature

Patient Signature

Date



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