NORTH SHORE DENTAL GROUP, LLP

450 PLANDOME ROAD
MANHASSET, NEW YORK 11030-1943
Tel: 516-627-3535 Website: www.northshoredentalgroup.com Fax: 516-627-3621

PATIENT REGISTRATION

Last Name:_____ **First Name:** _____**MI**_____

Please circle one: Mr. Mrs. Miss Ms. Dr. Fr. Rev. Jr. Sr. I II

Home Address_____ _____ _____ _____
Street City State Zip Code

Home Phone___-_____-_____**Cell**_____-_____-_____**E-mail address:**_____

SOCIAL SECURITY #: _____-_____-_____ **DOB:** _____/_____/_____

Please circle the letter that best describes you:

R = RESPONSIBLE FINANCIAL PARTY S = SPOUSE C = CHILD O = OTHER

EMPLOYER: _____**ADDRESS:** _____

PHONE: _____-_____-_____ **ext.**_____ **FAX:** _____-_____-_____**E-mail:** _____

INFORMATION RE: PERSON RESPONSIBLE FOR PAYMENT (if not the patient)

Last Name:_____ **First Name:**_____

Please circle one: Mr. Mrs. Miss Ms. Dr. Fr. Rev. Sr. I II

Address:_____
Street City State Zip Code

Home Phone:_____-_____-_____**Cell:**_____-_____-_____**E-mail Address:**_____

SOCIAL SECURITY #: _____-_____-_____ **DOB:** _____/_____/_____

Please circle the letter that best describes you: R = RESPONSIBLE G = GUARANTOR

EMPLOYER: _____**ADDRESS:**_____

PHONE: _____-_____-_____ **ext.**_____ **FAX:** _____-_____-_____**E-mail:** _____

HOW DID YOU FIND OUT ABOUT NORTH SHORE DENTAL GROUP (WHOM SHALL WE THANK FOR REFERRING YOU?) _____

MEDICAL AND DENTAL HISTORY

PATIENT'S NAME: _____DATE: _____/_____/_____

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and effectively. Incorrect information can be dangerous to your health.

MEDICAL HISTORY WARNING

WARNING: Anesthetics and other medications that may be necessary in your dental treatment may interact with prescriptions, over the counter drugs and medications, and illicit drugs. Please make sure forms are completed accurately. You must inform the doctor of all drugs and medications you are now, or have ever taken. You must, THESE INTERACTIONS MAY BE SERIOUS AND FATAL!!! Please also disclose if you are a recovering alcoholic or drug user.
All information will be held in the strictest confidence and will not be disclosed without your prior approval.
FEMALE PATIENTS: are you taking birth control pills? Some antibiotics used in dentistry may decrease the effectiveness of birth control pills.
NOTE: ANY CHANGE IN YOUR HEALTH STATUS SHOULD BE REPORTED TO THIS OFFICE AS SOON AS POSSIBLE.

INSTRUCTIONS:

- **WRITE THE ANSWER TO EACH QUESTION IN THE SPACE PROVIDED.**
- **WRITE "NO" IF THE QUESTION DOES NOT APPLY TO YOU.**
- **DO NOT LEAVE ANY QUESTION UNANSWERED.**
- **IF THE QUESTION IS NOT UNDERSTOOD, IF YOU ARE NOT SURE OF THE ANSWER, OR HAVE ANY QUESTIONS, INDICATE SO BY WRITING "?" AND DISCUSS THE MATTER WITH THE DOCTOR.**
- **ALL OF THE QUESTIONS MUST BE ANSWERED IN INK.**

Name of Primary Care Physician: _____ Phone #: _____-_____

Address: _____

Date of Last Visit: _____/_____/_____ Reason for visit:_____

Are you currently under the care of a Physician? _____

If Yes, for what reasons or conditions?_____

ARE YOU REQUIRED TO PREMEDICATE BEFORE APPOINTMENTS?
(CIRCLE ONE): *YES* *NO*

If Yes, Describe reason for Pre-medication: _____

Are you currently taking any medications? If Yes, What medications and for what reasons and conditions?

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

DENTAL INSURANCE PLAN INFORMATION ***If APPLICABLE***

Primary Insurance Company: _____ Group Number: _____

Secondary Insurance Company: _____ Group Number: _____

HAVE YOU EVER HAD OR BEEN TREATED FOR THE FOLLOWING CONDITIONS? WRITE "YES" OR "NO". IF "YES" WRITE CONDITION ON LINE PROVIDED:

(YES/NO)

Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease?
_____(_____)

Heart trouble, heart attack, angina, heart surgery?
_____(_____)

Do you have trouble catching your breath when climbing stairs?
_____(_____)

Do you have a pacemaker, or irregular heartbeats?
_____(_____)

Do you have artificial joints, vascular grafts, or artificial heart valve?
_____(_____)

Do you have stomach or intestinal disease, ulcers?
_____(_____)

Do you have abnormal blood pressure, excessive bleeding, or anemia?
_____(_____)

Do you have breathing problems such as: asthma, tuberculosis, hay fever, or sinusitis?
_____(_____)

Cancer, x-ray treatments, or chemotherapy?
_____(_____)

Do you have diabetes?
_____(_____)

Do you have frequent urination (night or day)?
_____(_____)

Hepatitis, jaundice, or liver disease?
_____(_____)

Kidney problems or renal dialysis?
_____(_____)

Venereal disease, HIV positive, AIDS?
_____(_____)

Blood transfusion in the last 8 years?
_____(_____)

Drug addiction or abuse (including alcohol)?
_____(_____)

Do you have more than 2 drinks a day?
_____(_____)

Psychiatric treatment, nervousness?
_____(_____)

Epilepsy or seizures?
_____(_____)

Thyroid disease?
_____(_____)

Do you smoke or use "snuff" or chew tobacco?
_____(_____)

A stroke, convulsions, or fainting spells?
_____(_____)

Tumors or growths?
_____(_____)

Arthritis or rheumatism?
_____(_____)

Allergic reaction to medications? (E.g. Penicillin, local anesthetics, aspirin, codeine, etc?
_____(_____)

Have you ever had a major operation? If Yes, Describe:
_____(_____)

Have you ever had a serious injury to your head or neck? If Yes, Describe:
_____(_____)

Have you lost or gained10 pounds in the last year?
_____(_____)

Are you on a special diet? If Yes, for what reason and describe:

_____(_____)

Are there other problems about your health of which you are aware?

_____(_____)

FOR WOMEN ONLY

YES/NO

Are you pregnant?

_____(_____)

Do you expect to become pregnant in the near future?

_____(_____)

Are you using hormonal contraception (are you on the pill)?

_____(_____)

Do you have PMS?

_____(_____)

DENTAL HISTORY

YES/NO

Are you having pain or discomfort at this time?

_____(_____)

Do you feel very nervous about having dental treatment?

_____(_____)

How long ago was your last visit to a dentist?

_____(_____)

Reason for your last visit?

_____(_____)

Do you have any of your x-rays or dental records available?

_____(_____)

In respect to any previous dental treatment have you: Ever had a bad experience in the dental office?

_____(_____)

Ever fainted?

_____(_____)

Had an allergic reaction?

_____(_____)

Had abnormal bleeding?

_____(_____)

Any other complications during or following dental treatments? If Yes, Describe:

_____(_____)

Do your gums bleed when you brush or eat?

_____(_____)

Does food catch between your teeth?

_____(_____)

Do you have sore spots around or between your teeth?

_____(_____)

Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth Flaring, or are some of your teeth becoming loose?

_____(_____)

How often do you brush each day? ___ONCE ___TWICE ___AM ____PM ____LUNCHTIME

What kind of toothbrush do you use? Hard_____Soft _____Medium_____Nylon_____Natural bristle____

Do you brush predominantly [ ] up and down, [ ] sideways, [ ] circles?

_____(_____)

Do you floss?

_____(_____)

Are any of your teeth sensitive to heat, cold or pressure?

_____{_____}

Do you ever get a "twinge" when you bite on something hard?

_____(_____)

Do you grind your teeth or clench your jaws?

_____(_____)

Have you been told you make noise with your teeth at night?
_____(_____)

Do you have a pain or clicking in the jaw joint around your ear?
_____(_____)

Do you have trouble opening wide?
_____(_____)

Do your jaws get tired easily?
_____(_____)

Do you have and do you get any lumps or growths in your mouth?
_____(_____)

Do you get cold sores, herpes, or mouth ulcers?
_____(_____)

Do any of your teeth ache?
_____ (_____)

Does your mouth frequently feel dry, taste bad or "burn"?
_____(_____)

Do you feel the need to suck on candy or mints, or cough drops?
_____(_____)

Are you happy with the way your teeth look?
_____(_____)

Do you wear dentures, If Yes; do they cause pain or problems?
_____(_____)

Do you have any other dental complaint such as "bad taste", etc.?
_____(_____)

Do you or your partner have a problem with snoring?
_____(_____)

To the best of my knowledge, the foregoing questions have been accurately answered. I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or other health practitioners. I give the doctor permission to use any photographs taken for educational and commercial purposes. I also give permission to obtain copies of records and x-rays from my previous dentist(s) Dr. _____.

INSURED PARTIES ONLY: I hereby authorize payment directly to North Shore Dental Group of the group insurance benefits otherwise payable to me. I understand I am financially responsible for any charges not covered by my insurance(s). I authorize release of any information relating to my dental benefits and claims.

_____ Date____/_____/____
Insured's Signature

_____ Date____/_____/____
Signature of person completing the form

Reviewed by Dr. _____ Date ___/____/____

UPDATED HISTORY

_____
_____
_____
_____
_____
_____
_____
_____
_____

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FINANCIAL POLICY

In our continue commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable.

Please check one of the following payment options**:**

- **Accounting courtesy** for pre-payment in full with cash or check on major treatment.
- **Credit card:** Visa, Mastercard, Discover, and American Express.

  Credit card: _____ expires: _____
- **Financial Plans:** Care Credit or Dental Fee Plan**.**
- **Office Payment Plan. (**For Major Treatment only**).**
  It is anticipated your treatment will require more than one (1) visit. For your convenience, the treatment may be paid in ____ payments of $_____.
- **Orthodontic treatment:** Monthly payment schedules are established with a major credit card on file.

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solutions possible to treat your personal situation.

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

*Please note your appointment time is always **reserved exclusively for you**, we require 24 hours notice for any cancellation or a $50 per wasted half hour charge may be charged to your account. For appointments over one hour, 48 hours notice is required to avoid charge.*

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due to be paid in full within sixty (60) days of date of service, regardless of whether or not my insurance benefits have been received. If I should fail to pay what I owe, the cost of any collection proceedings will be paid by me and (1.3%) per month interest (16% per year) will be charged on accounts 60 days from treatment date. I also give permission to North Shore Dental Group; LLP to check for credit references if any balance is not paid at the time the treatment is rendered. We are here to assist you in any way possible. Please make your questions and concerns known to our team

.

Signature of Responsible Party_____ Date_____

TO BETTER MEET YOUR EXPECTATIONS
PLEASE COMPLETE THIS LAST SECTION

PERSONAL DENTAL NEEDS SURVEY

1. Please rate in order of importance, your primary concerns regarding your dental care. (The most important being #1, least = #4)

_____ Preventative Dental Health Care _____ Cost and Affordability

_____ Excellence and Quality of Service _____ Other

2. Please rate, as in Question #1, what a dentist has to do to gain your confidence.

_____Show me what he/she is doing or needs to do so I can clearly understand what is being done.

_____Make sure I feel comfortable and informed at all times.

3. Please circle the level of fear you have about your dental visits (10 being the greatest fear):

1 2 3 4 5 6 7 8 9 10

4. I would like to know about these options available to me for maximizing my comfort during my visit.

_____ Music and Earphones _____ Sedative Medication

_____ Nitrous Oxide _____ Relaxation Videos

DESIGN YOUR DENTAL HEALTH GOALS

5. How often do you:
a. Have your teeth professionally cleaned? _____
b. Have routine dental examinations? _____
c. Floss your teeth? _____
d. Have an oral cancer exam? _____

6. How often do you think you <u>should</u>:

a. Have your teeth professionally cleaned? _____
b. Have routine dental examinations? _____
c. Floss your teeth? _____
d. Have an oral cancer exam? _____

7. Do you have?
a. Any missing teeth? _____
b. Untreated dental disease? _____
c. Problems with bad breath? _____
d. An attractive smile? _____

8. Are concerned about
a. Un-replaced missing teeth? _____
b. Reoccurring or untreated dental disease? _____
c. Pyorrhea or gum disease? _____
d. Mouth odor? _____
e. The appearance of your smile? _____

9. In the past have you? *(Please rate on a scale of 1-10, 10 being the best)*
a. Had a good experience with dentistry? _____
b. Been given good home care instructions? _____

c. Made a commitment to your oral health? _____
d. Been happy with the appearance of your smile? _____
e. Been pleased with the quality of care delivered? _____

10. Given my past experience, I expect to keep my natural teeth until ___

11. In the future, I am interested in: (on a scale of 1-10, 10 being the most interested)

a. An exceptional dental office experience
1 2 3 4 5 6 7 8 9 10
b. Ideal dentistry- complete and comprehensive
1 2 3 4 5 6 7 8 9 10
c. High quality dentistry- durable and long lasting
1 2 3 4 5 6 7 8 9 10
d. Low cost, high maintenance dentistry
1 2 3 4 5 6 7 8 9 10
e. Disease prevention program
1 2 3 4 5 6 7 8 9 10

12. Ideally, I would like to keep my natural teeth until_____

13. How would you describe the likelihood of keeping your teeth and gums healthy for a lifetime?
1 2 3 4 5 6 7 8 9 10

14. Is there anything else that you think we should know about your care and treatment in our office?_____
_____

AGAIN, THANK YOU FOR TAKING THE TIME TO ASSIST US IN GETTING TO KNOW YOU.

WE LOOK FORWARD TO A LONG AND HAPPY PROFESSIONAL RELATIONSHIP.

PLEASE FEEL FREE TO COMMENT ON YOUR EXPERIENCE IN OUR OFFICE UP TO NOW:_____
_____
_____