Three Village Prosthodontics

100 South Jersey Avenue, Suite #29, East Setauket, New York 11733 • (631) 689 – 5555

PATIENT INFORMATION

Full Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ________________________ Preferred Name: ____________

☐ Single ☐ Married Date of Birth: ____________________ Social Security #: ____________________

Home Address: ________________________ City: ________________ State: _____ Zip: ____________

Home Phone: ________________ Mobile Phone: ________________ Email: ____________________

How do you prefer to be contacted: ☐ Home ☐ Mobile ☐ Business ☐ Email

Occupation: ______________ Employer: ____________________ Employer's Phone: ____________________

Employer's Address: ________________________ City: ________________ State: _____ Zip: ____________

Emergency Contact Name: ________________ Relationship: ______________ Phone: ________________

Whom may we thank for referring you to our office? ____

DENTAL INSURANCE

Name of Insured Person: ____ Date of Birth: ______________

Insurance Co. Name: ________________________ Phone: ______________ Group #: ________________

Address: ________________________________ City: ____________________ State: _____ Zip: __________

Subscriber #: ____________________________ Employer: ________________ State: _____ Zip: __________

ADDITIONAL DENTAL INSURANCE

Name of Insured Person: ____ Date of Birth: ______________

Insurance Co. Name: ________________________ Phone: ______________ Group #: ________________

Address: ________________________________ City: ____________________ State: _____ Zip: __________

Subscriber #: ____________________________ Employer: ________________ State: _____ Zip: __________

RESPONSIBLE PARTY

If the person responsible for payment is someone other than the patient, please complete the section below so that we have the appropriate billing information for your account.

Name of Person Responsible for Payment: ____________________ Relationship to Patient: ____________________

Home Address: ____________________________ City: ________________ State: _____ Zip: ____________

Home Phone: ________________ Mobile Phone: ________________ Email: ____________________

Employer: ____ Employer's Phone: ____________________

Employer's Address: ________________________ City: ________________ State: _____ Zip: ____________

HEALTH HISTORY

Physician Name: ______________________________ City: ____________________ Phone Number: ____________________

Pharmacy: __________________ Address: ______________________________________ Phone Number: ____________________

Are you allergic to any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Latex	☐	☐	Local anesthesia	☐	☐	Other allergies (If yes, please explain)
☐	☐	Penicillin	☐	☐	Sulfa Drugs			______________________________

Do you have, or have you ever had, any of the following?

Yes	No		Yes	No	
☐	☐	Acid reflux	☐	☐	High cholesterol
☐	☐	Alcohol or drug addiction	☐	☐	High or low blood pressure
☐	☐	Anemia	☐	☐	HIV or AIDS
☐	☐	Artificial joint replacement	☐	☐	Kidney problems
☐	☐	Artificial heart valve	☐	☐	Liver problems
☐	☐	Asthma or COPD	☐	☐	Lung problems
☐	☐	Cancer	☐	☐	Osteopenia or osteoporosis
☐	☐	Chemotherapy	☐	☐	Psychiatric care
☐	☐	Congenital heart defect	☐	☐	Radiation therapy
☐	☐	Corticosteroid treatment	☐	☐	Rheumatic/scarlet fever
☐	☐	COVID	☐	☐	Sinus problems
☐	☐	Dental phobia or anxiety	☐	☐	Sleep apnea and/or snoring
☐	☐	Diabetes	☐	☐	Stomach or intestinal problems
☐	☐	Epilepsy or seizures	☐	☐	Stroke
☐	☐	Excessive bleeding	☐	☐	Thyroid problems
☐	☐	Fainting spells or dizziness	☐	☐	Tuberculosis
☐	☐	Heart attack or heart problems	☐	☐	Tumors or growths
☐	☐	Heart pacemaker	☐	☐	Other health problems
☐	☐	Heart murmur	☐	☐	Are you pregnant?
☐	☐	Hepatitis	☐	☐	Are you on birth control?
☐	☐	Herpes or cold sores			

Please provide additional information for all “Yes” responses:

____

____

MEDICATION LIST

Please list your prescribed and over-the-counter medications as well as any vitamins or supplements you are currently taking:

Name:	Indication:	Dose:	Frequency:

PAST MEDICAL & SURGICAL HISTORY

Have you been hospitalized in the past 5 years? **Yes** ☐ **No** ☐

If yes, please state reason, date, and duration: ____

____

Have you had any surgeries? **Yes** ☐ **No** ☐

If yes, please state type of procedure and date: ____

____

SMOKING HISTORY

Do you smoke cigarettes? ☐ **Yes** ☐ **No**

If yes, how many packs per day? __________________ How many years? ___________

Are you a former smoker? ☐ **Yes** ☐ **No**

If yes, how many packs per day? __________________ How many years? ___________

Do you smoke electronic cigarettes, vape, or use any other tobacco products? ☐ **Yes** ☐ **No**

DENTAL HISTORY

What is the reason for your dental visit today? ____

____

Are you currently experiencing any pain or sensitivity in your mouth? ☐ **Yes** ☐ **No**

If yes, please explain: ____

____

____

When was the last time you saw a dentist? ____

When was your last professional cleaning? ____

When was the last time you had dental x-rays? ____

Where were they taken? ____

How often do you brush your teeth? ____

How often do you floss your teeth? ____

	Yes	**No**
Have you ever been treated for periodontal (gum) disease?	☐	☐
Do you feel that you can chew well with your teeth?	☐	☐
Do you grind or clench your teeth?	☐	☐
Do you ever have jaw pain or jaw muscle soreness?	☐	☐
Have you ever worn a nightguard or been told that you should?	☐	☐
Are you satisfied with the way your smile looks?	☐	☐
Are you satisfied with the color of your teeth?	☐	☐
Are you unsatisfied with any teeth or restorations?	☐	☐
Would you like to discuss esthetic improvements that can be made to your smile?	☐	☐

Notice of Privacy Practices Acknowledgement

I affirm that the information that I have provided today is up to date and accurate to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical status.

I understand that under the Health Insurance Portability and Accountability (HIPAA) Act of 1998, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

> Plan, conduct, and direct my treatment and follow-up among the multiple healthcare providers who may be involved, directly and/or indirectly, in that treatment.
>
> Obtain payment from third-party payers.
>
> Conduct normal healthcare operations such as quality assessments.

I have received, read and understand your Notice of Privacy Practices containing a complete description of the use and disclosures of my health information. I understand that Three Village Prosthodontics has the right to change its Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy.
I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Three Village Prosthodontics is not required to agree to my requested restrictions, but if they do, they are bound to abide by them.

Name: ____

Signature: ____

Date: ____