

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for answers that require clarification or any other information you think I should have. Thank you for your cooperation.

### Patient Information

Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
 Name: \_\_\_\_\_  
                    Last                    First                    MI  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
 Business Name: \_\_\_\_\_  
 Business Address: \_\_\_\_\_  
 Business Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
 Spouse's Occupation: \_\_\_\_\_ Spouse's Business Phone: \_\_\_\_\_  
 Referred by: \_\_\_\_\_ Most convenient appointment time: \_\_\_\_\_

### Medical Health

General Health (please check):      EXCELLENT       GOOD       FAIR       POOR

Name and phone number of your Physician: \_\_\_\_\_

Are you under a doctor's care at this time for any medical condition?      YES       NO

Date of last complete physical: \_\_\_\_\_

Any hospitalizations in the past 2 years?      YES       NO

Are you taking any medication or vitamins?      YES       NO       Please List All: \_\_\_\_\_

Are you taking any medication for osteoporosis?      YES       NO       Please List: \_\_\_\_\_

Are you ever been treated for:

Heart disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Heart murmur	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Rheumatic fever	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Jaundice	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Abnormal blood pressure	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Asthma or hay fever	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Ulcers	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Sinus trouble	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Tuberculosis or lung disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Cough	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Hepatitis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Epilepsy	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Arthritis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Anemia	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Stroke	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Congenital heart lesions	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Glaucoma	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cancer	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Thyroid problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Have you ever had a cardiac shunt or valve replaced?      YES       NO       Have you ever had cardiac bypass surgery?      YES       NO

Have you ever had a hip or other joint replaced?      YES       NO       Are you HIV / AIDS positive?      YES       NO

Have you ever been treated (other than diagnostic) with x-ray or radiation?      YES       NO

ARE YOU ALLERGIC TO:      PENICILLIN       CODEINE       LOCAL INJECTED ANESTHETICS       OTHER  \_\_\_\_\_

Are you subject to prolonged bleeding?      YES       NO

Are you subject to fainting spells?      YES       NO

Do you have excessive urination and/or thirst?      YES       NO

Are you pregnant?      YES       NO       If so, how long? \_\_\_\_\_

## Dental Health

Reason for visit? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Are you happy with your smile? \_\_\_\_\_

YES  NO

If you could change anything about your smile what would it be? \_\_\_\_\_

Do your gums bleed while brushing? YES  NO

Do you feel twinges of pain when your teeth come in contact with:

a. hot foods or liquids, i.e., soup, coffee, tea, etc.? YES  NO

a. cold foods or liquids, i.e., ice cream, cold fruit, etc.? YES  NO

Do you feel pain to any of your teeth when brushing or flossing them? YES  NO

Do you normally take antibiotics before any dental treatment? YES  NO

Do your gums feel tender or swollen? YES  NO

Do you clench or grind your jaw during the day or while sleeping? YES  NO

Does your jaw ever feel tired? YES  NO

Do you snore? YES  NO

Have you ever been diagnosed with Sleep Apnea? YES  NO

If there is anything that we could do to make your visit to our office pleasant, please let us know: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Interest

All balances unpaid for 60 days or more will accrue interest at the rate of 1% per month, or 12% per annum. Payments and other credits are deducted from the previous balance before computing the finance charge

## Appointments

So that we may assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees. Once an appointment is made, please remember this time is reserved for you: AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY. OTHERWISE A CANCELLATION CHARGE WILL BE MADE.

## Insurance

To avoid misunderstanding regarding dental insurance, we wish our patients to know that ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

Patient's Signature \_\_\_\_\_

**Joseph F. LoPinto DDS, PC**  
**200 Central Park South, Suite 201**  
**New York, New York 10019**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE  
OF PRIVACY PRACTICES**

**\*\*You may refuse to sign this acknowledgement\*\***

I, \_\_\_\_\_, have  
received a copy of this office's Notice of Privacy Practices

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*Please Print Name*

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*Signature*

*Date*

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*For Office Use Only*

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refusal to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (please specify)

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