

Richard M. Bloom, DDS, PC  
516-579-7744

## Registration & Health History

### Patient Information:

Patient's Name : \_\_\_\_\_ Soc.Sec.# \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Age : \_\_\_\_\_ Sex: Female Male

Residence Street : \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Business: \_\_\_\_\_

Cell Phone# \_\_\_\_\_ Email Address: \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed

Employment Status: Employed/ Not Employed/ Retired/ Full Time Student

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Referred By: \_\_\_\_\_

Purpose Of This Appointment: \_\_\_\_\_

Who Will Pay This Account? : \_\_\_\_\_

### Insurance Information:

Relationship To Insured: \_\_\_\_\_ Insured's Date Of Birth: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_

Dental Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group Plan #: \_\_\_\_\_

**Please turn over form and complete the health history portion. —>>**

Do You Have, Or Have You Had Any Of The Following?  
Please Indicate **YES** or **NO** In The Space Provided:

- |   |  |                                    |
|---|--|------------------------------------|
| <input type="checkbox"/> Any Heart Problems                                       | <input type="checkbox"/> Allergies to Novocain                             | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Murmur   | <input type="checkbox"/> Allergies to Penicillin                           | <input type="checkbox"/> Herpes    |
| <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Allergies to _____                                | <input type="checkbox"/> HIV/ AIDS |
| <input type="checkbox"/> High Blood Pressure                                      | <input type="checkbox"/> Tuberculosis (persistent cough)                   |                                    |
| <input type="checkbox"/> Low Blood Pressure                                       | <input type="checkbox"/> Prosthetic Implant (Hip, Knee, Heart Valve, Etc.) |                                    |
| <input type="checkbox"/> Abnormal Bleeding From a Cut                             |  |                                    |
| <input type="checkbox"/> Allergies To Latex, Banana, Avocados, Chestnuts or Kiwis | <input type="checkbox"/> Diabetes  |                                    |

Other Physical Conditions: \_\_\_\_\_

Are You Taking Any Medication? No Yes –List Meds You Are Taking: \_\_\_\_\_

\_\_\_\_\_

Date Of Last Medical Examination: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone#: \_\_\_\_\_

Are You Presently Under The Care Of A Physician?: Yes No

How Long Since You Have Been To A Dentist?: \_\_\_\_\_

Women: Are You Pregnant? Yes No. Are You Taking Birth Control Pills? Yes No

**I understand** that dental insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I clearly understand and agree that all services rendered me are charged directly to me and that **I am personally responsible for payment**. I also agree that if I suspend or terminate my care and treatment, any fees for services rendered me will be immediately due and payable. Additionally it is agreed that should the fee for professional services not be paid in accordance with the provisions herein, there shall be included in the computation of the amount due, an amount of reasonable attorney's fees in any collection proceedings. Finances charges will be applied to all past due accounts at the rate of 1.5% per month. Appointments missed or not canceled with at least 24-hour notice will be charged a fee of at least thirty dollars.

**Patient's Acknowledgment:** I hereby acknowledge that I received and/or reviewed the office Privacy and Financial policies for Dr. Richard M. Bloom. I have been given the opportunity to ask any questions I may have regarding these policies.

Patient's or Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_