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 any 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 ☐	NO ☐	Heart murmur	YES ☐	NO ☐
Rheumatic fever	YES ☐	NO ☐	Jaundice	YES ☐	NO ☐
Abnormal blood pressure	YES ☐	NO ☐	Asthma or hay fever	YES ☐	NO ☐
Ulcers	YES ☐	NO ☐	Sinus trouble	YES ☐	NO ☐
Tuberculosis or lung disease	YES ☐	NO ☐	Cough	YES ☐	NO ☐
Diabetes	YES ☐	NO ☐	Hepatitis	YES ☐	NO ☐
Epilepsy	YES ☐	NO ☐	Arthritis	YES ☐	NO ☐
Anemia	YES ☐	NO ☐	Stroke	YES ☐	NO ☐
Congenital heart lesions	YES ☐	NO ☐	Glaucoma	YES ☐	NO ☐
Cancer	YES ☐	NO ☐	Thyroid problems	YES ☐	NO ☐

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 CANCELATION 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

____

Please Print Name

____

Signature *Date*

____

For Office Use Only

____

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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