Welcome To

Flushing Family Dentistry!

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.
Please fill out this form completely. The better we communicate,
the better we can care for you.

1. About You

Date: _____

Name:_____ __Dr./Mr./Mrs./Ms.

I prefer to be called: _____ Sex: ☐ M ☐ F

Birthdate: ____/____/____ Age: _____ SS#: _____

Home Address: _____

City:_____State:_____ Zip: _____

E-mail: _____

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home #: _____ Cell #: _____
Work #: _____ Ext: _____

Employer: _____

Occupation: _____

Best time and number to reach you: _____

Who may we thank for inviting you to our office?
_____

We like to thank our patients for referrals.
May we mention your name?: ☐ Yes ☐ No

Previous Dentist _____
Last Visit: _____

2. Spouse/Parent Information

His/Her Name: _____

Birth Date:____/____/_____ SS#:_____

Work #: _____ Ext: _____

Person responsible for account: _____

Relation: _____ SS#: _____

Billing Address:
_____

Work #: _____ Home #: _____

3. Dental Insurance

PRIMARY

Dental Coverage: ☐ Yes ☐ No

Ins. Co. Name: _____

Insured's Name: _____

Relation: _____

SS#: _____ ID#: _____

Birthdate: ____/____/_____ Employer: _____
_____

SECONDARY

Dental Coverage: ☐ Yes ☐ No

Ins. Co. Name: _____

Insured's Name: _____

Relation: _____

SS#:_____ ID#: _____

Birthdate: ____/____/_____ Employer: _____

5. Emergency Contact

In case of emergency, is there someone nearby we can contact?

Name: _____

Relation: _____ Home #: _____

Work #: _____ Cell #: _____

6. Medical History

Do you have a personal physician? ☐ Yes ☐ No
Physician: _____

Phone: _____ Last Visit: _____/____/_____
Currently under care? ☐ Y ☐ N

6. Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor
Are you taking any prescription/over-the-counter or herbal supplemental drugs? ☐ Y ☐ N

Please list each one (if you have a list, please present list with this form: _____

_____

Have you ever taken Phen-Fen (Redux or Pondimin)? ☐ Y ☐ N

For Women: Are you taking birth control pills? ☐ Y ☐ N
Are you pregnant? ☐ Y ☐ N Week # _____
Are you nursing? ☐ Y ☐ N

Have you ever had any of the following diseases or medical conditions?

Heart Problems/Conditions …..……	Y	N
Blood Disorders (bleeding problems) …….	Y	N
Blood Transfusions …….	Y	N
High Blood Pressure ……...	Y	N
Stroke ……..	Y	N
Cancer/Chemotherapy ……	Y	N
Radiation Therapy ……..	Y	N
Diabetes ……..	Y	N
Epilepsy/Seizures ……	Y	N
Fainting Spells ……	Y	N
Artificial Joints ……..……..	Y	N
Back/Neck pain ……..	Y	N
Frequent Headaches ……	Y	N
Hepatitis ……..…….	Y	N
HIV/AIDS ……..……	Y	N
Tuberculosis ……..……..	Y	N
Psychiatric Disorders ……	Y	N
Acid Reflux/GERD ……..	Y	N
Liver problems ……..……	Y	N
Kidney problems …….	Y	N
Osteoporosis …….	Y	N

Please explain/list any serious medical conditions that you have ever had:

_____

_____

Do you smoke/use tobacco in any form? Y N Previously

Do you drink alcohol? Never Occasionally Weekly Daily
Do you use recreational drugs?
Never Occasionally Weekly Daily
What type? _____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Ibuprofen
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Penicillin
Y	N	Tetracycline	Y	N	Local Anesthesia	Y	N	Latex

Please list any other drugs/materials you are allergic to:

_____

7. Dental History

Why have you come to the dentist today?

_____

Are you currently in pain? …… Yes No

Have you had a serious/difficult problem associated with past dental work? ……. Yes No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ,,,,.,,, Yes No
Do you grind/clinch your teeth? …… Yes No
Do you snore or have sleep apnea? …….. Yes No
Have you had braces or Invisalign before? …. Yes No
Have you had oral surgery before? …….. Yes No
Have you had deep cleaning or gum surgery? Yes No
Do you have severe anxiety with dental work? Yes No
Do you feel you have a dry mouth? …… Yes No

In the past, have you required antibiotics before dental treatment?

Yes No

Reason for antibiotics: _____

Are you happy with your smile? ☐ Yes ☐ No
Would you like whiter teeth? ☐ Yes ☐ No
Would you like fresher breath? ☐ Yes ☐ No

How many times a day do you brush? _____

How many times a week do you floss? _____

8. Informed Consent

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence according to HIPAA regulations and it is my responsibility to inform this office of any changes in my medical status.

I also understand that if this office accepts my dental insurance, I am responsible for payment of my co-pay in full for services rendered the day of service. I also understand that I am responsible for payment of any deductibles and payments that my insurance does not cover.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____

Date: _____