delaire dental

# Patient Registration

## A. PATIENT INFORMATION

Name: *Last:* *First:* *Middle:*
Home Phone: ( )
Business/Cell Phone: ( )

Address: *Mailing Address:*
*City:* *State:* *Zip:*

Occupation and Employer Name:
Height: Weight:
Date of Birth: (m/d/y)
Sex: M F

SS # or Patient ID:
Marital Status:
Email Address:

Emergency Contact:
Relationship:
Home Phone: ( )
Business/Cell Phone: ( )

Whom may we thank you for referring you?

## B. PRIMARY INSURANCE

(Please bring your insurance card with you to the appointment)

Insurance Company:
Group Policy #
Subscriber #

*If Person Responsible for Account is not Patient in Section A, please fill out the following:*

Person Responsible for Account: *Last:* *First:* *Middle:*
Relationship to Patient:

Address: *Mailing Address:*
*City:* *State:* *Zip:*

Occupation and Employer Name:
Business/Cell Phone: ( )
Date of Birth: (m/d/y)
Sex: M F

SS #:
Email Address:

## C. ADDITIONAL INSURANCE

(Please bring your insurance card with you to the appointment)

Is the Patient covered by an additional Insurance? ☐ Yes ☐ No

Insurance Company:
Group Policy #
Subscriber #

*If Person Responsible for Account is not Patient in Section A, please fill out the following:*

Person Responsible for Account: *Last:* *First:* *Middle:*
Relationship to Patient:

Address: *Mailing Address:*
*City:* *State:* *Zip:*

Occupation and Employer Name:
Business/Cell Phone: ( )
Date of Birth: (m/d/y)
Sex: M F

SS #:
Email Address:

## D. ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____("Insurance Company(ies)")
Name of Insurance Company(ies)

and assign directly to Dr. Hyon Chol (Michael) Lee all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Insurance Company(ies) to pay by check made out and mailed to Delaire Dental, 900B 347 5th Avenue, New York, NY 10016.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative: ……Date: ……..

Please print name of Patient, Parent, Guardian or Personal Representative: ……...Date: ……..

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# Health History

## A. DENTAL INFORMATION

Reason for Today's Visit: _____ Date of last dental care: _____

Former Dentist: _____ Date of last dental X-rays: _____

Address: _____

Check in the box ☑ if you have had problems with any of the following

| | | |
|---|---|---|
| ☐ Bad breath | ☐ Grinding teeth | ☐ Sensitivity to hot |
| ☐ Bleeding gums | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets |
| ☐ Clicking or popping jaw | ☐ Periodontal treatment | ☐ Sensitivity when biting |
| ☐ Food collection between teeth | ☐ Sensitivity to cold | ☐ Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

## B. MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? _____ If yes, describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check in the box ☑ if you have had problems with any of the following

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Cortisone Treatments | ☐ Hepatitis | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Persistent cough | ☐ High Blood Pressure | ☐ Shortness of Breath |
| ☐ Artificial Heart Valves | ☐ Cough up Blood | ☐ HIV / AIDS | ☐ Skin Rash |
| ☐ Artificial Joints | ☐ Diabetes | ☐ Jaw Pain | ☐ Stroke |
| ☐ Asthma | ☐ Epilepsy | ☐ Kidney Disease | ☐ Swelling of Feet or Ankles |
| ☐ Back Problems | ☐ Fainting | ☐ Liver Disease | ☐ Thyroid Problems |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tobacco Habit |
| ☐ Cancer | ☐ Headaches | ☐ Pacemaker | ☐ Tonsillitis |
| ☐ Chemical Dependency | ☐ Heart Murmur | ☐ Radiation Treatment | ☐ Tuberculosis |
| ☐ Chemotherapy | ☐ Heart Problems | ☐ Respiratory Disease | ☐ Ulcer |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Rheumatic Fever | ☐ Venereal Disease |

## C. MEDICATIONS

List medications you are currently taking: _____

Pharmacy Name: _____ Phone: (_____) _____

## D. ALLERGIES

Check in the box ☑ if you have the following allergies:

| | | |
|---|---|---|
| ☐ Local anesthetic | ☐ Codeine | ☐ Hay fever / seasonal |
| ☐ Aspirin | ☐ Metals: _____ | ☐ Animals: _____ |
| ☐ Penicillin or other antibiotics | ☐ Latex | ☐ Food: _____ |
| ☐ Sulfa drugs | ☐ Iodine | ☐ Other: _____ |

Note: Both Doctor and Patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature: ……Date: ……..……..