

ShinDDS | StrickmanDDS | ZiarDMD  
286 Madison Avenue, #1803 | New York, NY 10017 | 212 683 4428

Name (Last, First, Middle) \_\_\_\_\_  Male  Female Birth Date \_\_\_/\_\_\_/\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ (Apt) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Patient's Social Security Number \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

Who is responsible for this account?  Self  Spouse  Guardian  Other \_\_\_\_\_

Insurance Subscriber's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Insurance \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Birth Date \_\_\_/\_\_\_/\_\_\_ Subscriber's ID or Social Security Number \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_ Employer \_\_\_\_\_

I, the undersigned, certify that I (or my dependent) have insurance coverage as written above, and assign directly to **Jennifer Shin, DDS, PC** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. An examination and diagnosis will determine my proper dental treatment. I understand that it is my responsibility to inform my provider(s) of any information concerning my physical or mental condition that may be relevant to my care. I understand that my treatments and disclosure of health information will not violate privacy issues. I understand there may be a need to consult with other health care providers. I voluntarily authorize the release of my Protected Health Information as required from another health care provider and I authorize the use of my Protected Health Information by Drs. Shin, Strickman, and/or Ziar until my treatment plan is completed. I authorize this office to bill me for the services rendered. I have read and understood the above and voluntarily consent to care. PHOTO RELEASE: I hereby release and discharge (photographer) from all and any claims and demands ensuing from or in connection with the use of photographs, including any and all claims for libel and invasion of privacy.

We strive to provide the highest quality of dental care while attempting to accommodate each patient's schedule. We provide reserved time slots for each patient. Canceling an appointment at the last minute or failing to come in at all limits our ability to meet the scheduling needs of our other patients. We request cancellations 24 hours in advance. A cancellation fee of \$125 will be charged to you to cover our minimum overhead. Thank you for your cooperation and consideration of our staff and other patients.

I have read and understood the procedures and policies. Patient's signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

In case of emergency, contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Date of last dental exam \_\_\_/\_\_\_/\_\_\_

Which statement best reflects you?

- I have an emergency (or I have pain) and want immediate relief or assistance.
- I would like a traditional cleaning and exam and may be interested in understanding my oral health.
- I value my teeth and would like to keep them for a lifetime, but would like to proceed slowly.
- I have dental problems, wish to retain my teeth for a lifetime, and would like to correct these problems as soon as possible.
- I want a lifetime of good dental health, but need a dentist who can address other health issues that affect my total health.

How would you describe your anxiety level?

- I am not nervous. I have had good dental experiences in the past.
- I am a little anxious. After all, I am at the dentist's office.
- I am very worried. It is difficult for me to be here.

Have you ever had any of the following oral conditions?

- |  |   |   |   |  |
|--|---|---|---|--|
| <input type="checkbox"/> dry mouth           | <input type="checkbox"/> offensive breath         | <input type="checkbox"/> lip/cheek biting         | <input type="checkbox"/> clicking/popping jaw | <input type="checkbox"/> burning mouth |
| <input type="checkbox"/> sensitive teeth     | <input type="checkbox"/> orthodontic treatment    | <input type="checkbox"/> grinding/clenching teeth | <input type="checkbox"/> thrush/candidiasis   | <input type="checkbox"/> loose teeth   |
| <input type="checkbox"/> bleeding gums/mouth | <input type="checkbox"/> jaw tiredness/pain       | <input type="checkbox"/> ulcers                   | <input type="checkbox"/> stained teeth        | <input type="checkbox"/> neck pain     |
| <input type="checkbox"/> morning headaches   | <input type="checkbox"/> crooked/misaligned teeth |   |   |  |

Are you satisfied with your smile? Yes|No If you are not happy with your smile, what would you like to change? \_\_\_\_\_

We would like to make you feel comfortable and safe. If there is anything you need, please do not hesitate to ask.

What is your favorite song or artist? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Phone Number \_\_\_\_\_ Date of Last Medical Exam \_\_\_\_/\_\_\_\_/\_\_\_\_

**Have you ever had any of the following conditions?**

- Yes|No AIDS
- Yes|No anemia
- Yes|No angina
- Yes|No arthritis
- Yes|No rheumatism
- Yes|No asthma
- Yes|No back problems
- Yes|No cancer
- Yes|No chemical dependency
- Yes|No chemotherapy
- Yes|No circulatory problems
- Yes|No cortisone treatments
- Yes|No cough, persistent or bloody
- Yes|No diabetes
- Yes|No emphysema
- Yes|No epilepsy
- Yes|No fainting or dizziness
- Yes|No glaucoma
- Yes|No headaches
- Yes|No heart problems
- Yes|No hepatitis type \_\_\_\_\_
- Yes|No herpes
- Yes|No HIV positive
- Yes|No hypertension
- Yes|No jaundice
- Yes|No jaw pain
- Yes|No kidney disease
- Yes|No liver disease
- Yes|No low blood pressure
- Yes|No nervous problems
- Yes|No pelvic inflammatory disease
- Yes|No PPD positive

- Yes|No psychiatric care
- Yes|No radiation treatment
- Yes|No respiratory disease
- Yes|No scarlet fever
- Yes|No sinus trouble
- Yes|No skin rash
- Yes|No special diet/weight loss
- Yes|No stroke
- Yes|No swollen feet/ankles
- Yes|No swollen neck glands
- Yes|No thyroid problems
- Yes|No tonsillitis
- Yes|No tuberculosis
- Yes|No tumors or growths
- Yes|No ulcer
- Yes|No venereal disease

**Have you ever been diagnosed with:**

- Yes|No artificial heart valves
- Yes|No artificial joints, screws
- Yes|No bleeding abnormally
- Yes|No blood disease
- Yes|No congenital heart lesions
- Yes|No heart murmur
- Yes|No hernia repair
- Yes|No mitral valve prolapse
- Yes|No pacemaker
- Yes|No rheumatic fever

**Have you ever taken any of these medications?**

- Yes|No blood thinners: coumadin, warfarin

- Yes|No diet medication: dexfenfluramine, fen-phen, pondimin, redux
- Yes|No levoxyl
- Yes|No synthroid

**Are you allergic to:**

- Yes|No aspirin
- Yes|No barbiturates
- Yes|No codeine
- Yes|No ibuprofen
- Yes|No latex
- Yes|No local anesthesia
- Yes|No metals (gold, nickel, etc.)
- Yes|No penicillin
- Other \_\_\_\_\_

**Women:**

- Yes|No are you pregnant?
- Yes|No are you nursing?
- Yes|No are you taking birth control?

**Have you ever been hospitalized?**

Yes|No Please describe: \_\_\_\_\_

**Please print all medications you are taking:**

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

**Do you need to take antibiotics for prophylaxis?** Yes|No **Patients with heart or valvular defects, stents, prosthetic joints, or a history of taking fen-phen diet pills should take antibiotics before having a dental procedure to minimize bacterial endocarditis or other infections.**

Do you have or have you had any other diseases or medical problems NOT listed on this form? \_\_\_\_\_

Do you now or have you ever used cigarettes, cigars, pipes, chewing tobacco, other? Yes|No

What is/was the amount per day? \_\_\_\_ For how many years? \_\_\_\_

To the best of my knowledge, all of the preceding answers are accurate. If I have any change in my health or my medications, I will immediately inform the dentist at my next appointment.

Patient's Name (Please Print) \_\_\_\_\_

Patient's signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_