Welcome to our practice!

Please fill out these forms completely. The better we commucate, the better we can better care for you. Our goal is to help you achieve and maintain maximum oral health.

Patient Information

Name_____ Date_____

Name you prefer to be called_____ DOB_____Age_____

Address_____City_____State_____Zip_____

Social Security#_____ Single___ Married___ Partnered___ Divorced___ Widowed___

Home Phone _____ Cell Phone_____

Business Phone_____ E-mail _____

Occupation_____ Interests, sports, hobbies_____

Who may we thank for referring you to us? _____

Dental History

Date of Last Dental Examination _____ Previous Dentist_____

Reason for Today's Visit _____

Please indicate any history of the following:	Y	N
Have you had any serious problems associated with dental treatment?		
Have you had serious injury to your face, head or teeth?		
Are you currently experiencing pain in any part of your mouth?		
Are any of your teeth sensitive to hot, cold, sweets?		
Do your gums bleed when you brush?		
Do you have any loose or broken fillings?		
Do you have any loose or broken teeth?		
Do you clench or grind your teeth?		
Does your jaw click or pop?		
Have you ever had TMJ (jaw joint) problems?		
Do you experience bad breath?		
Does food collect between your teeth?		
Do you gag easily?		
Do you feel your teeth could be whiter?		
Do you snore, choke or have episodes of not breathing while you sleep?		
Do you frequently experience unrefreshing sleep?		
Do you feel nervous or anxious about having dental treatment?		

Please let us know if there is anything you would like to change about your smile: _____

Please share with us anything that will make you more comfortable during your visit: _____

Medical History

General Health: Excellent ___ Good___ Fair___ Poor___ Date of Last Physical Exam_____

Physician's Name_____ Phone_____

Address_____

Have you been admitted to a hospital or needed emergency care during the past two years? Y__ N __ If yes, Please explain_____

Are you currently under the care of a physician? Y__ N__ Explain, if so _____

If you are currently using any medications or supplements, please list each one and the amount taken each day and reason for each:

_____

Have you ever been on a Bisphosphinate Medication ex: Fosamax, Boniva, Aconel,Atelvia, Didronel? ___

Have you ever taken Phen-Fen or Redux? _____

Are you on a special diet? _____ Explain, if so_____

Are you allergic to any of the following: Penicillin__ Tetracycline__ Sulfa Drugs__ Aspirin__ Codeine__

Dental Anesthetics__ Latex__ Metals ___ Other_____

Please indicate any history of the following:	Y	N
Blood Pressure High Low		
Heart problems Please explain:		
Artificial Heart Valve		
Pacemaker		
Implanted Defibrillator		
Bleeding disorder or Prolonged bleeding from extractions, surgery or trauma		
Arthritis		
Artificial Joints, Pins, etc.		
Diabetes		
Anemia		
Stroke		
Dizziness or Fainting		
Headaches		
Epilepsy, Seizures or Convulsions		
Lyme Disease		
Cancer or Malignancy		
Benign Tumors or Growths		
Radiation or Chemotherapy		
Gastrointestinal Disorders or Ulcers		
Kidney Disease		
Liver Disease or Hepatitis		
Thyroid Disease		

	Y	N
Renal Disease		
Hay fever, Asthma, or Breathing Problems		
Sinus Problems		
Respiratory Disease or Disorder		
Glaucoma		
Vision Problems		
Hearing Loss		
Drug Addiction		
AIDS or HIV		
Venereal Disease		
Herpes		
Eating Disorder		
Do You Smoke or Vape?		
Do you Use Chewing Tobacco?		
Do You Use Controlled Substances?		
Women only: Are you pregnant? If yes, what month? _____		
Trying to get pregnant?		
Nursing?		
Are you taking birth control pills?		
Men only: Are you currently taking Nitrates, Viagra, Cialis?		

To the best of my knowledge, all of the preceding answers and information provided are true.

If I ever have any change in my health, I will inform the doctors at my next appointment.

Patient Signature_____ Date_____

Garden City Dental Group

901 Stewart Avenue, Suite 225
Garden City, New York 11530

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign Notice this Acknowledgement"

I, _____

Have been informed of this office's Notice of Privacy Practices.

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

__ Individual refused to sign

__ Communications barriers prohibited obtaining the acknowledgment

__ An emergency situation prevented us from obtaining acknowledgment

__ Other (Please Specific)

_____

_____

MANDATORY PHARMACY UPDATE:

(DUE TO MANDATORY CHANGES IN New York STATE REGARDING PRESCRIPTION PROCESSING)

Patient Name:_____ D.O.B : _____

Pharmacy Name: _____Telephone # _____

Pharmacy Address: _____

City _____ State_____ Zip _____

ELECTRONIC APPOINTMENT CONFIRMATIONS:

E-Mail: _____ MOBILE PHONE: _____

PHOTO RELEASE

I hereby consent that any radiographs (x-ray), photographs and video, of me, may be used by Garden City Dental Group for means of record keeping, educational and promotional purposes**;** in office, out of office, on social media and on the company's website**.** I understand that if used, my name will not be disclosed. I do not expect compensation, financial or otherwise, for the use of these photos.

Signature_____ ___ ___Date_____