🗖 delaire dental

Patient Registration

A. PATIENT INFO	ORMATION

Name			Home Phone:		Business /Call Dhange		
Name:	Eint	M:11.	nome Phone:		Business/Cell Phone:		
Last:	First:	Middle:	()		()		
Address:							
Mailing Address:			City:		State:	Zip:	
Occupation and Employe	r Name:		Height:	Weight:	Date of Birth: $(m/d/y)$	Sex:	
						Μ	F
SS # or Patient ID:			Marital Status:		Email Address:		
Emergency Contact:			Relationship:	Home	e Phone: Busi	ness/Cell P	hone
Emergency Contact.			Relationship.	(none.
W/l= = +1= +1=	<u> </u>			() ()	
Whom may we thank you	for referring you?						
	NOR		(1)		• • • •		
B. PRIMARY INSURA	NCE		(P	lease bring your	insurance card with you t	o the appoi	ntment)
Insurance Company:			Group Policy #		Subscriber #		
If Person Responsible for Acce	ount is not Patient in Se	ection A, please fill out the followi	ng:				
Person Responsible for A	count:		Relationship to P	ationt			
-		Mille	Relationship to r	auciit.			
	First:	Middle:					
Address:						-	
Mailing Address:			City:		State:	Zip:	
Occupation and Employe	r Name:		Business/Cell Ph	one:	Date of Birth: $(m/d/y)$	Sex:	
			()			Μ	F
SS #:			Email Address:				
C. ADDITIONAL INS	URANCE		(Pl	ease bring your	insurance card with you to	the appoir	(tment)
C. IEDITIONE INC.	CIUNICE		(1)	ease bring your	insurance card with you to	o the appoint	minim
Is the Patient covered by	an additional Insuran						
is the Fatient covered by:	an additional msurai	$100^{\circ} \square 108 \square 100$					
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Insurance Company:			Group Policy #		Subscriber #		
			Group Policy #		Subscriber #		
			Group Policy #		Subscriber #		
Insurance Company:		rction A, please fill out the followi			Subscriber #		
Insurance Company:		rction A, please fill out the followi			Subscriber #		
Insurance Company: If Person Responsible for Acce	ount is not Patient in Se	rction A, please fill out the followi	ng:	atient	Subscriber #		
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Insurance Company: If Person Responsible for Acco Person Responsible for A Last:	ount is not Patient in Se	rction A, please fill out the followi Middle:	ng:	'atient:	Subscriber #		
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Insurance Company: If Person Responsible for Accord Person Responsible for A Last: Address: Mailing Address:	ount is not Patient in Se ccount: First:		ng: Relationship to P <i>City:</i>		State:	Zip:	
Insurance Company: If Person Responsible for Accord Person Responsible for A Last: Address:	ount is not Patient in Se ccount: First:		ng: Relationship to P			Zip: Sex:	
Insurance Company: If Person Responsible for Accord Person Responsible for A Last: Address: Mailing Address:	ount is not Patient in Se ccount: First:		ng: Relationship to P <i>City:</i>		State:	1	F
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🗖 delaire dental

A. DENTAL INFORMATION

Reason for Today's Visit: Former Dentist: Address:	Date of last dental X-rays:					
Check in the box \blacksquare if you have had problems with any of the following	5					
	th or broken fillings Sensitivity to sweets tal treatment Sensitivity when biting					
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). If yes I No Have you had any serious illnesses or operations? If yes, describe: If yes, give approximate dates:						
(Women) Are you pregnant?	$\Box \text{ Yes } \Box \text{ No} \qquad \qquad \text{Taking birth control pills? } \Box \text{ Yes } \Box \text{ No}$					
Check in the box \blacksquare if you have had problems with any of the following	5					
Anemia Cortisone Treatments Arthritis, Rheumatism Persistent cough Artificial Heart Valves Cough up Blood Artificial Joints Diabetes Asthma Epilepsy Back Problems Fainting Blood Disease Glaucoma Cancer Headaches Chemical Dependency Heart Murmur Chemotherapy Heart Problems Circulatory Problems Hemophilia	HepatitisScarlet FeverHigh Blood PressureShortness of BreathHIV / AIDSSkin RashJaw PainStrokeKidney DiseaseSwelling of Feet or AnklesLiver DiseaseThyroid ProblemsMitral Valve ProlapseTobacco HabitPacemakerTonsillitisRadiation TreatmentTuberculosisRespiratory DiseaseUlcerRheumatic FeverVenereal Disease					
C. MEDICATIONS						
List medications you are currently taking: Phone: ()						
D. ALLERGIES						
Check in the box \checkmark if you have the following allergies:						
□ Local anesthetic □ Codeine	 Hay fever / seasonal Animals: Food: Other: 					
Note: Both Doctor and Patient are encouraged to discuss any and all rele	evant 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:						

Delaire Dental * Dr. Michael Lee, DMD * 900B 347 5th Avenue, New York, NY 10016 * p: 646.412.5540 * f: 646.998.8050 * www.delairedental.com