CONFIDENTIAL

Steven M. Alper, DMD
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(212) 777-8160

Personal Information

Date: _____

Patient Name: _____ How do you wish to be addressed? _____

Date of Birth: _____ Gender: _____ Social Security Number: _____

Driver's License No.: _____ State: _____

Residential Address (Street, City, State, Zip): _____

Telephone number that you wish to be reached on: _____ ☐ Home ☐ Mobile ☐ Work ☐ Other

**All calls (except returning emergency calls) will be made between M-F from 9a - 6p*

Email Address: _____

**Email is our preferred and primary method of communication for appointment confirmations, prescription requests, and billing matters. Please provide an email address only if you are willing to receive email correspondence from our office.*

In Case of Emergency, please contact (Name/Phone number): _____

Who is responsible for this account? ☐ Myself ☐ Other: _____

Whom may we thank for this referral? _____

If search engine search, please specify:

Search engine used (i.e. Google, Bing, Yahoo, etc.): _____

Keyword(s) used: _____

Other Family Members in the practice? _____

Insurance Information

(Please enter subscriber/insurance holder information)

Employee Name: _____ Date of Birth: _____

Relationship to Patient (If not self, please see below):* _____

Employer Name: _____ Present Position: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Telephone of Insurance Company: _____

Program/Policy/Group Number: _____

Subscriber ID Number/Social Security Number: _____

*****If you are a dependent on insurance plan, we will need both yours and the subscriber's information.
Please enter **dependent** information below.

Dependent Name: _____ ID Number: _____ Date of Birth: _____

****If you have secondary insurance, please complete the additional form on page 5 of this document.**

Dental History

Purpose of initial visit?

Any problems that you are aware of?

Date and purpose of last visit?

Last teeth cleaning? _____

Please select Yes (Y), No (N), or Not Sure (NS) for the following questions.

Have you made regular dental visits? ☐ Y ☐ N ☐ NS

Were dental x-rays taken? ☐ Y ☐ N ☐ NS

Have you ever had any problems or complications with previous dental treatment? ☐ Y ☐ N ☐ NS

If yes, explain:

Do you clench your jaw or grind your teeth? ☐ Y ☐ N ☐ NS

Does your jaw click or pop? ☐ Y ☐ N ☐ NS

Do you have frequent headaches, neck aches, or shoulder aches? ☐ Y ☐ N ☐ NS

Have you experienced any pain, tightness or soreness in the muscles of your face, ear or temples? ☐ Y ☐ N ☐ NS

Does food get caught in your teeth? ☐ Y ☐ N ☐ NS

Are any of your teeth sensitive to hot/cold/sweets/pressure? ☐ Y ☐ N ☐ NS

Do your gums bleed or hurt? When? _____ ☐ Y ☐ N ☐ NS

Do you experience dry mouth? ☐ Y ☐ N ☐ NS

How often do you brush your teeth? _____

Do you use dental floss? How often? _____ ☐ Y ☐ N ☐ NS

Are you unhappy with the appearance of your teeth? ☐ Y ☐ N ☐ NS

How do you feel about your teeth in general? _____

Do you feel that your breath is offensive at times? ☐ Y ☐ N ☐ NS

Have you ever had gum treatment or surgery? ☐ Y ☐ N ☐ NS

If so, please explain:

Have you ever had orthodontic work? ☐ Y ☐ N ☐ NS

Medical History

When applicable, please select Yes (Y), No (N), or Not Sure (NS) for the following questions.

Are you under a physician care? Since when? _____

Physician's Name: _____ Telephone: _____

When was your last complete physical exam? _____

Are you allergic to any medications or substances (please list):

Do you have any other allergies or hives? _____

Any problems with penicillin, antibiotics, anesthetics, metals, latex or other medications? If so, please explain.

Are you pregnant or suspect that you may be pregnant? ☐ Y ☐ N

Have you ever been treated for or told that you might have heart disease? ☐ Y ☐ N

Do you have a pacemaker, an artificial heart valve implant or been diagnosed with mitral valve prolapse? ☐ Y ☐ N

Have you ever had rheumatic fever, other serious illness or major surgery? Artificial Joints? If so, please explain.

Are you aware of any heart murmurs? ☐ Y ☐ N

Blood pressure condition? ☐ High ☐ Low ☐ Normal ☐ Not Sure

Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ☐ Y ☐ N

Are you taking any medications or substances? If so, please list. (Please include birth control)

Do you routinely take vitamins, herbal supplements or natural products? ☐ Y ☐ N

Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? ☐ Y ☐ N

Do you have inflammatory diseases, such as arthritis or rheumatism? ☐ Y ☐ N

Do you have any artificial joints/prosthesis? ☐ Y ☐ N

Have you ever bled excessively after being cut or injured? ☐ Y ☐ N

Are you diabetic? ☐ Y ☐ N

Do you or have you had T.B.? ☐ Y ☐ N

Do you smoke, chew, use snuff or any other forms of tobacco? ☐ Y ☐ N

Do you regularly consume more than one or two alcoholic beverages a day? ☐ Y ☐ N

Medical History continued

Do you have any disease, condition, or problem not listed? If so, explain.

Is there anything else we should know about your health that we have not covered in this form?

Would you like to speak to the doctor privately regarding any issue?

Consent and Signatures

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. My consent to disclosure of records shall be effective until I revoke it in writing. I consent to the use of before and after photographs demonstration purposes. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

I attest to the accuracy of the information on this form.

I have received privacy policy.

Patient or Guardian's signature: _____

Office Use

Reviewed by: _____ **Date:** _____

*Please print forms and bring them to the office for your first appointment. **Please do not send sensitive material such as credit card numbers, social security numbers, Insurance ID numbers, etc via email.** Steven M. Alper, DMD PLLC is not responsible for any sensitive information that is sent in this manner.

Print Form

Secondary Insurance Information

(Please enter subscriber/insurance holder information)

Employee Name: _____ Date of Birth: _____

Relationship to Patient (If not self, please see below):* _____

Employer Name: _____ Present Position: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Telephone of Insurance Company: _____

Program/Policy/Group Number: _____

Subscriber ID Number/Social Security Number: _____

*****If you are a dependent on insurance plan, we will need both yours and the subscriber's information.
Please enter **dependent** information below.

Dependent Name: _____ ID Number: _____ Date of Birth: _____