Ortiz Dental Care

35a Guy Lombardo Ave
Freeport, NY 11520

Date:_________________

Name: ____________ _____________________
First Last

Sex: ☐ Male ☐ Female

Date of birth : _____/_____/_____ Age:_______

Social Security : _____/______/_______

Home Address :____________________________________

____
City State Zip-code

☐ Single ☐Married ☐Divorced/Separated ☐Widowed

Home phone# (____)______________ Cell #(_____)____________

Work phone#(_____)______________ Other( )-____________

EMAIL:______________________________________

Spouse Information

Name :______________ ________________ _______________
First Last

home phone# __(____)______________ Cell #(_____)__________

Insurance

Dental Coverage ☐ Yes ☐ No

Insurance Address:_____________________

____

Insurance phone #( )____________________

Insured's Name________________________
First Last
Date of birth:______/_______/______
Social security #_______/________/_____
Insured's employer:_______________________

Insured's address:______________________

Phone ( ) ____________________________

ID# _______________________________

Group #______________________

Maximum: $ _______ Deductible $ _______

Major _____% Basic____%
Prev______%

How did you hear of us ?____

Important

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature__________________________________ Date:________________________

Medical History **Dental History**

Did you have a personal Physician? Yes No

Physician Name:_______________________________________

Phone:____

Date of the last visit_______________________________
Your current physical health is: Good Fair Poor

Are you currently under the care of a physical___________

Are you taken any medications: Yes___ No___
If Yes please write them here: ____________________________________
____

Have you ever had any of the following diseases or medical problems?

Yes No Abnormal Bleeding
Yes No Aids
Yes No Alcohol/ Drug Abuse
yes No Anemia
yes No Arthritis
yes No Asthma
yes No Blood Transfusion
yes No Cancer
yes No Colitis
yes No Diabetis
yes No Difficulty breathing
yes No Epilepsy
yes No Glaucoma
yes No Heart attack/ surgery
yes No Hepatitis
yes No Herpes
yes No High blood pressure
yes No HIV
yes No Kidney Problems
yes No Liver Disease
yes No Low blood pressure'
yes No Lupus
yes No Psychiatric problems
yes No Stroke
yes No Thyroid
yes No Tuberculosis
yes No Ulcers
yes No Venereal Disease

Are you Allergic to any of the Following?

Y N Aspirin Y N Erythromycin Y N Latex
Y N Codeine Y N Jewelry/Metals Y N Penicillin
Y N Tetracycline Y N Dental Anesthetics

Why have you come to the dentist today ?
____

Are you currently in pain?______________
Do you require antibiotics before dental Treatment?__________________________

Your current dental health is :
Good Fair Poor
Are you Pregnant?______________________
If yes week # _________________________
Are you Nursing ______________________

Do you Floss Daily?___________________
Do your gums ever Bleed?_____________
Have you ever had gum Treatment?______

I understand that the information that I have given today is correct to the best of My knowledge. I also understand that this Information will be held in the strictest Confidence and it is my responsibility to Inform this office of any changes in my Medical status and personal information. I authorize the dental staff to perform any Necessary dental services that I may need During diagnosis and treatment, with my Informed consent.

______________________ ________
Signature Date.