BATTERY PARK
DENTAL GROUP

Battery Park Dental Group

375 South End Ave.
New York, NY 10280
Ph. (212) 619-4070 Fax: (212) 619-4098

www.BatteryParkDentalGroup.com

Please Complete and Return to Office

Name: Last First Middle

Address: Street, Apt. or P.O. Box # City State Zip code

Cell Phone: Home Phone: Work Phone:

Age: Yrs. Birth Date: Mo. Day Year Email Address ( ) Male ( )Married
( ) Female ( )Unmarried
( )Separated
( )Divorced

Social Security No: (if child, parents) **Whom may we thank for your referral?**

Occupation: Employer: How long employed?

Employer Address & Phone No:

Person responsible for bill: Age: Re lationship to Patient: ( ) Male Social Security No:
( ) Female
Driver's License No:

Address: Street, Apt. or P.O. Box # City State Zip code

Home Phone: Work Phone: Ext. Best Time to Call:

Occupation: Employer: How long Employed?

Employer Address & Phone No:

Insured Person's Full Name Date of Birth

Social Security Number Relati onship to Patient Work Phone

Insurance Company Name Group or Union Name Group or Local Numbers

Employer's Name Full Address of Employer

Is insured a patient? Yes No

CONSENT FOR SERVICES

Signature of Responsible Party Relationship Date

Credit Card Name & Number Expiration Date

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Medical History

1. Have you been under the care of a medical doctor during the past two years?.....❒Yes ❒No
   If yes: for what reason?_____
   Please provide the name, address, and telephone number of your physician.
   _____
   _____
9. Have you been a patient in the hospital during the past five years?.....❒Yes ❒No
   If yes: for what reason?_____
10. Have you taken any medicine or drugs during the past two years? If yes, please list:.....❒Yes ❒No
    _____
11. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspiring?
    ❒Yes ❒No If yes, please list:_____
    _____
11. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ❒Yes ❒No
    If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other
    If yes to any of the above, did you have a medical exam for heart issues? ..... ❒Yes ❒No
12. Are you aware of having an allergic (or adverse) reaction to any substance or medication?..... ❒Yes ❒No
    If yes, please explain:_____
13. Have you lost or gained more than 10 pounds in the last year?.....❒Yes ❒No
14. Are you on a special diet?.....❒Yes ❒No
15. Check any of the following which apply in either past or present:

❒Heart (Surgery, Disease, Attack)	❒ Ulcers	❒ Hepatitis A B C (circle)
❒ Chest Pain	❒ Diabetes	❒ Venereal Disease
❒ Congenital Heart Disease	❒ Thyroid Problems	❒ A.I.D.S./H.I.V. Positive
❒ Heart Murmur	❒ Glaucoma	❒ Cold Sores / Fever Blisters
❒ High/Low Blood Pressure	❒ Contact Lenses	❒ Blood Transfusion
❒ Mitral Valve Prolapse	❒ Emphysema	❒ Hemophilia
❒ Artificial Heart Valve / Pacemaker	❒ Chronic Cough	❒ Sickle Cell Disease
❒ Rheumatic Fever	❒ Tuberculosis	❒ Bruise Early
❒ Arthritis/Rheumatism	❒ Asthma	❒ Liver Disease / Yellow Jaundice
❒ Cortisone Medicine	❒ Hay Fever / Allergies / Hives	❒ Neurological Disorders
❒ Swollen Ankles	❒ Latex Sensitivity	❒ Epilepsy or Seizures
❒ Stroke	❒ Sinus Trouble	❒ Fainting or Dizzy Spells
❒ Diet (Special / Restricted)	❒ Radiation Therapy	❒ Nervous / Anxious
❒ Artificial Joints (hip, knee, etc.)	❒ Chemotherapy	❒ Psychiatric / Psychological Care
❒ Kidney Trouble	❒ Tumors	

16. Do you have any disease, condition or problem not listed? If so, please list.....❒Yes ❒No
    _____
    _____
17. **Women:** Are you pregnant or think you could be pregnant? Yes _____Months No **Nursing?** ❒Yes ❒No
18. Do you use birth control prescriptions?.....❒Yes ❒No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature _____Date _____

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Dental History

1. What is the reason for your visit today?_____
   _____
2. Date of last dental visit_____Last dental cleaning_____Last full mouth X-Rays_____
3. What was done at your last dental visit? _____
   _____
4. Previous Dentist's Name_____
   Address/State/Zip_____
   Telephone_____
5. How often do you have dental examinations?_____
6. How often do you brush your teeth?_____ How often do you floss? _____
7. Have you ever used or are currently using topical fluoride? .....❒Yes ❒No
8. What other dental aids do you use? (Interplak, toothpick, etc.)_____
9. **Do you have any dental problems now?** .....❒Yes ❒No
   If yes, please describe._____
10. Check any of the following which apply in either past or present:

❒Hot or Cold Sensitivity
❒ Sweets Sensitivity
❒ Biting or Chewing Sensitivity
❒ Experience bad odors or bad tastes
❒ Frequent cold sores, blisters or other legions
❒ Bleeding gums
❒ Painful gums
❒ Experienced gum disease
❒ Have tooth loss
❒ Loose teeth
❒ Change in your bite
❒ Food catches between your teeth
❒ Clench or grind teeth while asleep
❒ Clench or grind teeth while awake
❒ Bite lips or cheek regularly
❒ Hold foreign objects with teeth (i.e. pencil)
❒ Mouth breathe while awake or asleep

❒ Snore or other sleeping disorders
❒ Use, smoke, chew tobacco
❒ Orthodontic treatment
❒ Oral Surgery
❒ Periodontal treatment
❒ Your teeth ground or bite adjusted
❒ Received a bite plate or mouth guard
❒ Clicking or popping of jaw
❒ Pain (joint, ear, side of face)
❒ Difficulty opening / closing mouth
❒ Difficulty chewing on either side of mouth
❒ Head, neck, or shoulder aches
❒ Sore muscles (neck, shoulder)
❒ A serious injury to the mouth or head?
If so, please describe, including cause_____
_____
❒ Experience tired jaws, especially in the morning

11. Are you satisfied with your teeth's appearance?..... .....❒Yes ❒No
12. Would you like to keep all of your teeth all of your life? ....❒Yes ❒No
13. Do you feel nervous about dental treatment? ....❒Yes ❒No
    If so, what is your biggest concern?_____
14. Have you ever had an upsetting dental experience? .....❒Yes ❒No
    Please describe. _____
15. Have you ever been told to take a pre-medication prior to dental treatment? .....❒Yes ❒No
    If so, what is your biggest concern?_____

Is there anything else you would like us to know? Please describe. _____
_____
_____

Patient / Guardian Signature _____Date _____