MICHAEL L. GREENBAUM, DDS

Location

◯ Port Washington ◯ Woodbury

First Name **Last Name**

Date of Birth (MM/DD/YYYY **SSN**

Sex **Marital Status**

Please Select One Please Select One

Home Phone **Cell Phone**

Email

Home Address

Address Line 2

City **State**

Zip **Billing Address the same as above?**

◯ **Yes** ◯ **No**

NOTE: *If Billing Address is Different than Home Address, please fill out the following. Otherwise, you may move on to the Work Information section.*

Billing Address

Billing Address Line 2

Billing City **Billing State**

Billing Zip

Work Information

Employer **Work Phone**

Occupation

Emergency Contact

Full Name **Phone Number**

Relation

Pharmacy Information

Pharmacy Name **Pharmacy Phone Number**

Pharmacy Address

Pharmacy Address Line 2

Pharmacy City

Pharmacy Zip

Financial Information

Patient's Payment Details – Guarantor (Person responsible for paying the bill)

Guarantor Name **Date of Birth**

SSN **Relation to Patient**

Payment Method

◯ Cash ◯ Check ◯ Care Credit

Dental Insurance Information

Primary Dental Insurance Company - Subscriber and Insurance Company Details

Primary Insurance Company **Phone Number**

Insurance Company Address

Insurance Company Address Line 2

City **State**

Zip

Subscriber Name **Date of Birth (MM/DD/YYYY)**

SSN/ID **Group/Policy Number**

Patient's Dental History

Reason for today's visit

Please Select One

Are you in pain?

Please Select One

Please indicate any of the following problems:

- ☐ Discomfort, clicking or popping in jaw
- ☐ Blisters/Sores in or around the mouth
- ☐ Red, swollen or bleeding gums
- ☐ Lost/Broken Filling(s)
- ☐ Bad Breath
- ☐ Broken/Chipped Tooth
- ☐ Teeth grinding
- ☐ Ringing in Ears
- ☐ Stained teeth
- ☐ Locking Jaw
- ☐ Sensitive tooth, teeth or gums
- ☐ Active Decay/Cavity(ies)

Other:

Previous Dentist

Phone Number

Last Exam (MM/DD/YYYY)

Last dental x-rays (MM/DD/YYYY)

Last Cleaning (MM/DD/YYYY)

Have you ever had problems with previous dental treatment? If so, explain:

Patient's Dental History
(*continued)*

Times a day you brush?

Times a week you floss?

Would you like whiter teeth?

◯ Yes ◯ No

Have you had orthodontic treatment?

◯ Yes ◯ No

Patient's Medical History

Physician's Full Name

Physician's Phone

What medication are you taking?

- ☐ Nerve Pills
- ☐ Pain Killers
- ☐ Muscle Relaxers
- ☐ Stimulants
- ☐ Blood Thinners
- ☐ Tranquilizers
- ☐ Insulin
- ☐ Meds for Osteoporosis
- ☐ Vitamins/Supplements

Have you ever taken:

Bisphosphonates

◯ Yes ◯ No

Phen-fen/Redux

◯ Yes ◯ No

Patient's Medical History (*continued*)

Do you have or have you had any of the following diseases, medical condition or procedures?
(Control+ Click to select multiple)

Please Select Any Applicable
Heart Murmur
Blood Disease
Tuberculosis TB
Sinus Problems
Seizures/Epilepsy
Dizziness/Fainting
Alcohol/Drug Abuse
Congenital Heart Defect
G.I. Problem/Ulcers
Back/Neck Problems
Lung Disease
Kidney Problems
HIV+/ AIDS/ARC
Heart Attack/Stroke
Venereal Disease
Cold/Fever Blisters
Eating Disorder
Artificial Heart Valves
Emphysema/Asthma Diabetes/Hypoglycemia
Respiratory Problems
Liver Problems
Scarlet Fever
Rheumatic Fever
Thyroid Problems
Cosmetic Surgery
Blood Transfusion
Heart Surg./Pacemaker
Mitral Valve Prolapse
Psychiatric Problems
Heart Disease/Angina
Cancer/Tumor/Growth(s)
Chemotherapy/Radiation
X-ray or Cobalt Treatment
High/Low Blood Pressure
Shingles
Arthritis/Gout
Bruise Easily
Sleep Apnea
Frequent Thirst/Urination
Artificial Bones/Joints
Hepatitis
Leukemia
Allergies
Bleeding Problems/Anemia
Jaw Problems TMJ/TMD
Glaucoma
Chest Pain
Nervousness

Patient's Medical History (*continued*)

Please list any other surgeries or medical conditions you have or ever had:

Are you allergic to any of the following?

- ☐ Latex
- ☐ Aspirin
- ☐ Food Allergies
- ☐ Penicillin/ Amoxicillin
- ☐ Codeine
- ☐ Tetracycline
- ☐ Dental Anesthetics
- ☐ Other

Do you use tobacco?

◯ Yes ◯ No

For Women Only:

Are you taking birth control pills?

◯ Yes ◯ No

Are you taking hormonal replacement?

◯ Yes ◯ No

Are you pregnant?

◯ Yes ◯ No

Are you nursing?

◯ Yes ◯ No

Who referred you to our office?

Office Policy for canceled appointments without 24hr notice or no-shows is depending on the length of the appointment. If you have a 30min appointment it will be a $50 charge, 45min appointments $75, 1hr appointment $100. No further appointments will be made until it is paid in full. I understand the information listed above which has been fully explained to me.

I authorize the dentist to release any information, including diagnosis, treatment plans/records and radiographs to third party payers and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the dental group or dentist benefits that are, otherwise, payable to me. I understand that my dental insurance may pay less than the actual bill for service or may not cover certain treatment. I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies.

I understand that the information that I have given is accurate 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 the office of any changes in my medical status in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Consent

☐ I acknowledge that I have received a Notice of Privacy Practice from the above named practice.

Date (MM/DD/YYYY)