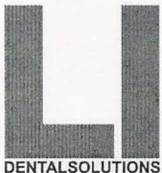

DENTALSOLUTIONS

Eric Chimon, DDS
640 Fulton Street
Suite 3
Farmingdale, NY 11735
516-694-2106
lidentalsolutions.com

New Patient Registration Form

Patient # ____________

SS # ____________

Birth Date: ___/___/___

Today's Date: ___/___/___

Referral Source: ____________

Welcome to L I Dental Solutions.

Please take a moment to review the form carefully first before completing it. Print clearly to avoid errors.

First Name ____________ MI ___ Last Name ____________

Address ____________ City ____________ State ___ Zip ______

Home Phone ____________ Cell ____________ Email ____________

Sex ☐M ☐F ☐Married ☐Single ☐Divorced ☐Separated ☐Minor Spouse/Parent's Name ____________

Occupation ____________ ☐ Self Employed ☐ On Disability ☐ Retired

Employer ____________ Work Phone ____________

Address ____________ City ____________ State ___ Zip ______

Emergency Contact ____________ Phone ____________ Relation ____________

INSURANCE INFORMATION

Person Responsible for this Account ____________ Relation to Patient ____________

Dental Insurance Carrier ____________ Group # ____________

Address ____________ City ____________ State ___ Zip ______

Phone ____________ Deductible Amount ____________ Maximum Annual Benefit ____________

DENTAL HISTORY

Reason for today's visit ____________ Date of last dental care ____________

Previous Dentist ____________ Phone ____________ Date of last dental X-rays ____________

Check (√) if you have had problems with any of the following:

☐Bad breath
☐Bleeding gums
☐Clicking or popping jaw
☐Food collection between the teeth
☐Grinding teeth
☐Loose teeth or broken fillings
☐Periodontal treatment
☐Sensitivity to cold
☐Sensitivity to hot
☐Sensitivity to sweets
☐Sensitivity when biting
☐Sores or growths in your mouth

MEDICAL INFORMATION

Physician's Name ____________ Phone ____________ Last Checkup ___/___

The following will help us determine if anything in your medical history will have an impact on the dental treatment you will be receiving or may require special attention from your physician prior to the dental procedure. Please check all the conditions that apply.

☐AIDS
☐Allergies
☐Allergies to anesthetics
☐Allergies to medications
☐Anemia
☐Arthritis
☐Artificial heart valve or joint
☐Artificial implant
☐Back problems
☐Blood disease
☐Cancer
☐Chemical dependency
☐Chronic diarrhea
☐Circulatory problems
☐Diabetes
☐Epilepsy
☐Headaches
☐Hemophilia
☐Hepatitis, jaundice other liver problems
☐High blood pressure
☐Kidney trouble
☐Low blood pressure
☐Nervous problems
☐Psychiatric care
☐Radiation treatment
☐Recent weight loss
☐Respiratory disease
☐Rheumatic fever
☐Sinus problems
☐Special diet
☐Sexually Transmitted Disease (STD)
☐Stroke
☐Swollen neck glands
☐Thyroid problems
☐Tuberculosis
☐Ulcers, stomach

New Patient Registration Form (cont)

OTHER MEDICAL CONCERNS

Please check all the conditions that apply.

☐ Do you have a medical condition that requires pre-medication prior to dental treatment? See notice below.
☐ Have you ever had abnormal bleeding related to slow blood clotting time?
☐ Have you ever had an adverse reaction to antibotics, anesthetics or other medication?
☐ Are you pregnant or suspect that you might be?
☐ Are you currently a nursing mother (breast feeding)?
☐ Are you a fearful of dental procedures or are especially pain sensitive?
☐ Do you have any medical condition that we should know about that might impact your dental treatment? Please explain.

____

Patients Requiring Pre-Medication Prior to Dental Visits – Please Read!

The American Heart Association and the American Academy of Orthopedic Surgeons have determined that there are some conditions that require you to take medication prior to your next dental visit. Some of these conditions include, but are not limited to:

- Unrepaired cyanotic congenital heart disease, including palliative shunts and conduits
- Completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first 6 months after the procedure
- Repaired congenital heart disease with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device
- Artificial joints

If you have or have had any of these conditions, pre-medication or clarification from your physician will be necessary before any dental treatment can be provided to you due to the health risks involved.
Please contact us at your earliest convenience concerning any of the listed medical conditions or if you have further questions.

Thank you!

PATIENT CONFIRMATION

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, as well as billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Patient signature ________________________________ Date ____________________