

LI Dental Solutions

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Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Sex: Male/Female _____

SS# _____ Birth Date: _____

Phone (Cell): _____ (Home): _____ (Work) _____ Email: _____

Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S

Address: _____
Street Apartment #

City State/Province Zip/Postal Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke | <input type="checkbox"/> Currently Pregnant? |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | Due date: _____ |

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Please List your medications: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

SS#/SIN: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State/Province _____ Zip/Postal Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street _____ City _____ State/Province _____ Zip/Postal Code _____ Phone _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street _____ City _____ State/Province _____ Zip/Postal Code _____

Insured's Employer Name: _____
Address: _____
Street _____ City _____ State/Province _____ Zip/Postal Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street _____ City _____ State/Province _____ Zip/Postal Code _____

Insured's Employer Name: _____
Address: _____
Street _____ City _____ State/Province _____ Zip/Postal Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____