# *Welcome to Dr. Louis Steinberg's Office!*

Date: _____

***About You….*** Patient's Name: _____ Legal Name: _____

___ Mr. ___ Ms. ___ Miss ___ Mrs. ___ Dr. *(If different)*

Address: _____

City: _____State: _____ Zip: _____ e-mail*:*_____

Phone: H _____ W1_____ W2_____ Cell_____ *Daytime* _____

DOB: _____ Sex: M____ F____ Marital: ___S___M___D___W Spouse:_____

SS#: _____ FT Student? ____ Where? _____

Work Address: _____City: _____ State: _____ Zip: _____

Employer Name: _____ How Long? _____ Occupation: _____

May we thank anyone for your referral? _____

***Insurance Information…*** Primary Insurance Co: _____ Phone #: _____

Insured Party: _____ Relation: _____ DOB: _____Group #:_____

Co. Address: _____ City: _____ State: _____ Zip: _____

SS#/Ins. I.D.#: _____Employer: _____ How Long? _____

I, _____ *(please sign)*, hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid for by my insurance company. Co-payment or deductible payments that apply must be paid on the day of treatment.

***In Event of Emergency …*** Whom should we contact? _____ Phone: H _____

Relation: _____ Phone: W1_____ Cell_____

Medical Doctor's Name: _____ Medical Doctor's Phone #: _____

***Account Information…*** Responsible Party (*Please select one)*: _____ Self _____Other **If other, please continue:**

Mr. ___ Ms. ___ Miss ___ Mrs. ___ Dr. ___ Name: _____

Address:_____

City: _____State:_____ Zip:_____ *Daytime Call:*_____

Phone: H _____W1_____ W2_____Cell_____e-mail_____

DOB: _____ Sex: M____ F____ Marital: ___S___M___D___W Spouse: _____

Driver's License, State & Number: _____ **Payment method:** ___ Cash ___Check ___Credit Card

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Credit Card Number: _____ Sec code: _____ Expiration Date: _____*(cont'd)*

## *Dental Information…*

Reason for today's visit: ___ Exam ___ Consultation ___ Emergency *If you are in pain, for how long?* _____
Please check if you have any of the following problems:

| | | |
|---|---|---|
| ___ Discomfort, clicking or popping in jaw | ___ Lost/broken filling(s) | ___ Stained teeth |
| ___ Red, swollen or bleeding gums | ___ Teeth grinding | ___ Locking jaw |
| ___ Sensitive tooth, teeth or gums | ___ Ringing in ears | ___ Bad breath |
| ___ Blisters/sores in or around the mouth | ___ Broken/Chipped tooth | ___ Other, *please indicate below:* |

_____

Name of Previous Dentist: _____ Phone: _____

Last Dental Exam: _____ Last Full Set of Dental X-Rays: _____ Times a day you brush? _____

What type of tooth brush bristles do you use: ___ Soft ___ Medium ___ Hard Times a week you floss? _____

How would you rate your smile (between 1 – 10)? _____ Comments: _____

***Medical History…*** Are you taking any of the following? ___ Nerve pills ___ Pain killers (e.g., aspirin, Tylenol, or ibuprofen) ___ Muscle relaxers ___ Stimulants ___ Blood thinners ___ Tranquilizers ___ Insulin ___ Other(s)_____
Do you have or have you ever had any of the following diseases or medical conditions?

| | | | |
|---|---|---|---|
| **Y N** Heart attack/ stroke | **Y N** Kidney problems | **Y N** Cancer/tumors | **Y N** Chemotherapy |
| **Y N** Heart surg/pacemaker | **Y N** Liver problems | **Y N** Shingles | **Y N** Asthma |
| **Y N** Heart murmur | **Y N** Respiratory problems | **Y N** Hepatitis | **Y N** Difficulty breathing |
| **Y N** Rheumatic fever | **Y N** Sinus Problems | **Y N** HIV+/AIDS/ARC | **Y N** Emphysema |
| **Y N** Mitral valve prolapse | **Y N** Stomach problem/ulcers | **Y N** Arthritis/rheumatism | **Y N** Leukemia |
| **Y N** Artificial valves | **Y N** Psychiatric problems | **Y N** Artificial bones/joints | **Y N** Anemia |
| **Y N** Heart disease | **Y N** Venereal disease | **Y N** Diabetes/hypoglycemia | **Y N** Scarlet fever |
| **Y N** Congenital Heart Defect | **Y N** Alcohol/drug abuse | **Y N** Fainting/seizures/epilepsy | **Y N** Bleeding problems |
| **Y N** Chest pains | **Y N** Tuberculosis TB | **Y N** Severe/frequent headaches | **Y N** Glaucoma |
| **Y N** High/low blood pressure | **Y N** Jaw problems TMJ/TMD | **Y N** Frequent neck pain | **Y N** Back problems |

Please list any other medical condition(s) you have or ever had: _____

_____
Are you allergic to any of the following? ___ Latex ___ Penicillin/amoxicillin ___ Tetracycline ___ Aspirin

___ Dental anesthetics ___Others: _____

Do you use tobacco? ___ No ___Yes *If yes,* how used? _____ How much? _____How long? _____
Please rate your general health from 1-10: _____ Do you wear contact lenses? ___ Yes ___ No
Have you ever taken the drug Phen-fen and /or Redux? ___ Yes ___ No
**For women:** Are you taking birth control pills? ___ Yes ___ No How many children have **you** had? _____
Are you pregnant?: ___ No ___Yes *If yes,* how long? ___ Are you nursing? ___ Yes ___ No

***We invite you*** to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
***Our policy*** requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our front desk personnel. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
***Please read carefully and sign below:***

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____
*Please check one*___Adult Patient ___Parent or Guardian