

CONFIDENTIAL PATIENT CASE HISTORY

Patients Name _____ **Date:** ___/___/___

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.

MEDICAL HISTORY

- Write the answer to each question in the space provided.
- If the question is not understood, you are not certain of the answer, or have any question, indicate so in the space, and discuss the matter with the doctor.
- All questions must be answered.
- Use black ink or ball point pen.

Name of Physician _____ Telephone _____

Address _____

Date of Last Visit _____ Reason for Last Visit _____

PATIENT REGISTRATION

Patient _____
LAST NAME FIRST NAME INITIAL PREFERRED NAME

Street Address _____

City _____ State _____ Zip _____ E-Mail _____

Sex: M F Age _____ Birth date _____ Single Married Widowed Separated Divorced

Home Telephone _____ Cell Phone # _____

Employed by _____ Occupation _____

Business Address _____ Business Telephone _____

Who is responsible for this account? _____ Relationship to patient _____

Social Security # _____ Spouse's Social Security # _____

Name of Dental Insurance Company _____ Group number _____

In case of emergency, who should be notified? _____ Telephone _____

Whom may we thank for referring you? _____

Name of Credit Card _____ Card # _____ Exp. Date _____

Dr. Brian Raskin, D.D.S.
 27 East Hawthorne Ave
 Valley Stream N.Y. 11580
 516-825-1100
 www.advanceddds.com

Patient Name _____ Date ____/____/____

1) Are you currently under the care of a physician? Yes No

2. Are you currently taking any medication? Yes No

HAVE YOU EVER HAD OR BEEN TREATED FOR:

3. Rheumatic fever, Rheumatic heart disease, heart murmur or congenital heart disease, or mitral valve prolapse? Yes No

4. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular heartbeats? Yes No

5. Stomach or intestinal disease? Yes No

6. Abnormal blood pressures, excessive bleeding, or anemia? Yes No

7. Breathing problems, asthma, tuberculosis, or hay fever? Yes No

8. Cancer, X-ray treatments or chemotherapy? Yes No

9. Diabetes? Yes No

10. Hepatitis, jaundice, or liver Yes No

11. Kidney problems or renal dialysis? Yes No

12. Venereal disease or AIDS? Yes No

13. A Stroke, convulsions, or fainting spells? Yes No

14. Tumors or growths? Yes No

15. Arthritis, rheumatism or artificial joint? Yes No

16. Allergic reactions to medications? Yes No

17. Have you ever had a major operation? Yes No

18. Have you ever had a serious injury to your head or neck? Yes No

19. Are you on a special diet? Yes No

20. Do you smoke? Yes No

21. Have you ever consulted or been treated by a psychiatrist, psychologist or counselor? Yes No

22. Are there any other problems about your health of which you are aware? Yes No

23. For women: are you pregnant? Yes No

DENTAL HISTORY

24. Ever fainted? Yes No

25. Had an allergic reaction? Yes No

26. Had abnormal bleeding? Yes No

27. Any other complications during or following dental treatment? If yes, describe.

28. Do your gums bleed while brushing or eating? Yes No

29. Does food catch between your teeth? Yes No

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Yes / No

30. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? .

33. Do you have pain or clicking in the jaw joint around your ear?

31. Are any of your teeth sensitive to heat, cold, or pressure?

34. Have your jaw muscles ever been sore?

32. Do you grind your teeth or clench your jaws?

35. Are there any sores or growths in your mouth?

36. Do any of your teeth ache?

Please Answer any question that relate to you:

37. What medications are you taking now? _____

38. Have you taken any drugs including illegal drugs in the last 48 hours? _____

39. Do you take herbs on a regular basis? _____

40. List any allergies to medications. _____

41. Are there any past or present problems with abuse of either alcohol or drugs? _____

42. Is there anything else about your medical history we should know? _____

NOTE: A CHANGE IN YOUR HEALTH STATUS SHOULD BE REPORTED TO THE OFFICE AT THE EARLIEST POSSIBLE TIME

For the best of my knowledge, the foregoing questions have been accurately answered.

PERMISSION TO RELEASE HEALTH INFORMATION

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payer, and/or health practitioners.

Signature of person completing form: _____

Print Name: If other than patient, indicate relationship: _____ Date _____

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FINANCIAL RESPONSIBILITY

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSEMENT FOR THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AND CO-INSURANCE AMOUNTS OR ANY OTHER BALANCES NOT PAID FOR BY YOUR INSURANCE CARRIER.

IN ORDER TO CONTROL OUR BILLING COSTS, WE REQUEST THAT OUR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. ANY ACCOUNTS DELINQUENT OVER 90 DAYS WILL BE SUBJECT TO SERVICE CHARGES OF 1.5% PER MONTH. IF THIS AMOUNT IS ASSIGNED TO AN ATTORNEY FOR COLLECTIONS AND/OR SUIT, THE PATIENT AND OR GUARANTOR WILL BE RESPONSIBLE FOR REASONABLE ATTORNEY FEES: COSTS OF COLLECTIONS, COURT COSTS AND INTEREST FROM DATE OF SERVICE.

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO DETERMINE ELIGABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT OF MY CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE TO WHICH I AM ENTITLED INCLUDING DENTAL INSURANCE TO:

DR. BRIAN M. RASKIN - ADVANCED DDS

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY THIS OFFICE IN WRITING; A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE THE RELEASE OF ALL INFORMATION NECESSARY TO SECURE PAYMENT.

SIGNED _____ DATE _____

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