Tribeca Dental Associates

80 Warren Street • New York NY · 10007 P 212.346.0893 • F 212.346.0894

SS#/SIN _____

Date _____

Thank you for selecting Tribeca Dental Associates!
To help us meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us -
we will be happy to help!

Patient Information CONFIDENTIAL

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Reason for your visit _____

Responsible Party

Name of Person responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Work Phone _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience we offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Care Credit ☐ Credit Card ☐ Visa ☐ Mastercard

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union of Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy / ID # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last S years?	☐	☐
If yes, please explain _____	☐	☐
_____	☐	☐
3. Are you taking any medication(s) Including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____	☐	☐
_____	☐	☐
4. Do you use tobacco?	☐	☐

5. Pleasecheck if you are allergic to or had any reactions to the following:

- ☐ Local Anesthetics (e.g. Novocain)
- ☐ Penicillin or any other Antibiotics
- ☐ Sulfa Drugs
- ☐ Barbiturates
- ☐ Sedatives
- ☐ Iodine
- ☐ Aspirin
- ☐ Any Metals (e.g. nickel. mercury, etc.)
- ☐ Latex Rubber
- ☐ Other (please list) _____

	Yes	No
6. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐

7. Please check if you have or had any of the following.

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ Swollen Ankles
- ☐ Fainting/Seizures
- ☐ Asthma
- ☐ Low Blood Pressure
- ☐ Epilepsy/Convulsions
- ☐ Leukemia
- ☐ Diabetes
- ☐ Kidney Diseases
- ☐ AIDS or HIV Infection
- ☐ Thyroid Problem
- ☐ Heart Disease
- ☐ Cardiac pacemaker
- ☐ Heart Murmur
- ☐ Angina
- ☐ Frequently Tired
- ☐ Anemia
- ☐ Emphysema
- ☐ Cancer
- ☐ Arthritis
- ☐ Joint Replacement or Implant
- ☐ Hepatitis/Jaundice
- ☐ Sexually Transmitted Disease
- ☐ Chest Pains
- ☐ Stomach Troubles/ Ulcers
- ☐ Easily Winded
- ☐ Stroke
- ☐ Hay fever/Allergies
- ☐ Tuberculosis
- ☐ Radiation therapy
- ☐ Glaucoma
- ☐ Recent Weight Loss
- ☐ Liver Disease
- ☐ Heart Trouble
- ☐ Respiratory Problems
- ☐ Mitral Valve Prolapse
- ☐ Other _____

8. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exams _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Diffculty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11.Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthdontic treatment?	☐	☐
13.Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
15.Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent / guardian if minor) Date