



Gary Minkowitz, DDS
Moraima De La Cruz - Minkowitz
55-23 69th Street
Maspeth, NY 11378

DATE FORM COMPLETED _____

NAME _____
Last First Mi

DATE OF BIRTH _____ Male Female
(check one)

SPOUSE/
PARENT's NAME _____
(If patient is a minor.) Last First Mi

PATIENT/PARENT SOCIAL SECURITY No.

PT'S PREFERRED NAME _____
Single Married Separated Divorced Widowed Minor

SPOUSE/PARENT SOCIAL SECURITY No.

RESIDENCE-STREET _____

PERSON TO NOTIFY IN CASE OF EMERGENCY THAT IS
NOT LIVING WITH YOU

CITY _____ STATE _____ ZIP _____

Name Phone #

PHONE: HOME- _____ CELL# _____

PRIMARY DENTAL INSURANCE COVERAGE

EMAIL ADDRESS _____

EMPLOYEE NAME _____

PATIENT/PARENT
EMPLOYED BY _____

EMPLOYEE DATE OF BIRTH _____

BUSINESS ADDRESS _____

EMPLOYER _____ #YRS: _____

PRESENT POSITION _____ BUS# _____

NAME OF INSURANCE CO. _____

SPOUSE EMPLOYED BY _____

EMPLOYEE SOCIAL SECURITY NUMBER

PRESENT POSITION _____ BUS# _____

SECONDARY DENTAL INSURANCE COVERAGE

WHO IS RESPONSIBLE FOR THIS ACCOUNT

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

OTHER FAMILY MEMBERS IN THIS PRACTICE

EMPLOYER _____ #YRS: _____

NAME OF INSURANCE CO. _____

WHOM MAY WE THANK FOR THIS REFERRAL

EMPLOYEE SOCIAL SECURITY NUMBER

- I give my authorization to Brett A Roufs D.D.S. to perform diagnostic procedures and treatment as necessary for care of my dental needs.
- I give my authorization for the release of any information concerning my (or my dependent's) health care, recommendations and treatments provided for the purpose of evaluating and filing insurance claims.
- I give my authorization for the release of any information concerning my (or my dependent's) health care, recommendations and treatment provided to another dentist.
- I hereby give my authorization for payment of insurance benefits directly to Brett A Roufs, D.D.S., otherwise payable to me.
- I understand that my dental care insurance provider may pay less than the actual bill for services. I also understand that it is my financial responsibility to pay the account in full. By signing below, I nullify all previous conflicting agreements and am in agreement to be held responsible for the payment of services not covered, completely or partially by my dental care provider.
- This office complies with the government regulation to inform patients of the privacy right act (HIPAA). I may request a copy at any time.
- All the information I have given is correct to the best of my knowledge, as affirmed with my signature below.

Signature of patient, parent or guardian

Date

Relationship to Pt

Please print firmly and clearly this is a scanned document.

Please list all medications and herbal supplements you are currently taking.

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

- | | | | |
|-----------------------------------------------|------------------------------------------------|-----------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Allergies (Seasonal) | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sensitivity to Metals |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pre-Medication | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Valve Implant | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Cancer/Growths | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sulfa Drug Allergy |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cephalosporin Class Allergy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Problem | Any Other Allergy _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | _____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | _____ |

Major Surgery _____ Is your heart disease under control with medication? Y / N

Are you pregnant? Y / N Due Date: _____ Are you under the care of a physician? Y / N

If yes, please explain: _____

Please write out any other concerns or health issues?

New Patients to the Practice

- Who was your previous dentist?

- Have you been treated for periodontal disease Y / N
- When was your last cleaning? _____
- When were your last xrays? _____
- Is there any dental work that you have already been informed is needed?

- Do you have dentures?
- Are you happy with the fit of your dentures? Y / N

Dental History

All Patients

Check any of the following that apply.

- Bad Breath
- Bleeding Gums
- Clicking Or Popping In jaw
- Food Collecting Between Teeth
- Grinding Teeth
- Loose Teeth Or Broken Fillings
- Sensitivity To Hot
- Sensitivity To Cold
- Sensitivity To Sweets
- Sensitivity When Biting
- Sores Or Growths In Your Mouth

- How often do you brush? _____
- Do you floss? Y / N
- Do you grind or clench your teeth? Y / N
- Have you had problems following a dental visit? Y / N

5. How do you rate your smile? (check)
Poor 1 2 3 4 5 6 7 8 9 10 Great!

6. What does your smile need to be a 10!

Did you know our practice offers all of the following dental care options?

- Cosmetic Dentistry
- Veneers
- Whitening - Home and In-Office
- General Family Care
- Periodontal Cleanings
- Orthodontics including
- INVISALIGN
- Implants
- Oral Surgery
- Denture Services
- Endodontics
- Digital Xray
- Laser Tissue Services

Signature of patient, parent or guardian

Date

Relationship to pt
