



Thank you for selecting our dental healthcare team!
 We will strive to provide you with the best possible dental care. 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.

Specialized Dentistry

State-of-the-art care to renew your smile

1001 E. Genesee St., Syracuse, NY 13210
 (315) 478-1001 • 1-877-478-1001
 www.SpecialtyDentist.com

Date _____

Soc. Sec. # _____

Home Phone _____

Cell Phone _____

E-mail _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

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

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Social Security # _____

Employer _____ Work Phone _____

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

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ ID# _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. 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 IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ ID# _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

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

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No		Yes	No
1. Are you under medical treatment now?.....	<input type="checkbox"/>	<input type="checkbox"/>	7. Are you allergic to or have you had any reactions to the following?.....	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (eg. novocaine).....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness?.....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine?.....	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates.....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives or Sleeping Pills.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use tobacco?.....	<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other Narcotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use alcohol?.....	<input type="checkbox"/>	<input type="checkbox"/>	8. Women Only:			(a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you wearing contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>	(b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>	(c) Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have or have you had any of the following?								
	Yes	No		Yes	No		Yes	No
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Hearth Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Bisphosphonates.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded.....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia or Blood Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Somach Troubles / Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have any disease, condition or problem not listed above that you think I should know about?.....								

Patient Dental History

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?.....	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had any orthodontic work?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever had any prolonged bleeding following extractions?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Have you ever had instruction on the correct method of brushing your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
a) Clicking?.....	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had instructions on the care of your gums?.....	<input type="checkbox"/>	<input type="checkbox"/>
b) Pain (joint, ear, side of face)?.....	<input type="checkbox"/>	<input type="checkbox"/>			
c) Difficulty in opening or closing?.....	<input type="checkbox"/>	<input type="checkbox"/>			
d) Difficulty in chewing?.....	<input type="checkbox"/>	<input type="checkbox"/>			
16. What is your chief dental concern?.....					
17. Do you like your smile?.....					
if not, explain:.....					

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 authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. It is also understood there will be a 2.0% Interest or \$5.00 Billing Charge, which ever is greater, for services over 30 Days. I have read all the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. Cancellations with less than 48 hours notice may incur a charge.

X _____
Signature of patient or parent if minor