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PATIENT REGISTATION AND MEDICAL HISTORY

Date: ______________ Social Sec #__________________ Responsible Party SS#_______________________

Patient ____ Preferred to be called: _____________
Last Name First Name Initial

Street Address: _________________________________ City: ________________ State: _____ Zip_________

Home Phone # ___________________ Cell Phone: ______________ Email address: _____________________

Sex: ☐ M ☐ F Age______ Birthdate__________ ☐Single ☐Married ☐ Divorced ☐ Widowed

Patient or Parent's Employer ___________________________ Work Phone ___________________________

Spouse or Parents Name: _____________________ Employer________________ Work Phone ___________

Whom May we Thank for Referring You?____

Person to Contact in Case of Emergency_____________________________ Phone____________________

PRIMARY DENTAL INSURANCE

Name of Insured____ Relation to Patient__________________

Birthdate of Insured: _________________ ID# or SS# ____________________ Effective Date: ___________

Insured's Employer: _____________________ Work Phone: ________________ Union or Local # _________

Insurance Company________________________ Group #_________ Subscriber/Member ID: _____________

Address of Insurance (on back of card): __________________________________ Phone # ________________

ADDITIONAL INSURANCE

Is Patient Covered by Additional Insurance: ☐ Yes ☐ No Subscriber Name: _____________________

Member ID: _______________________ Group #:___________ Birthdate: ___________________________

Insurance Name: _____________________________________ Phone Number: ________________________

Authorization: I hereby authorize my insurance company to pay to Dr. Michael Koyfman all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the office of Dr. Michael Koyfman to release all information necessary to secure the payment of benefits. I understand payment is due at the time of treatment and that I am financially responsible for all charges whether or not paid by insurance.

SIGNATURE: ____ DATE: _________________

(please complete Medical History Form on back)

DENTAL AND MEDICAL HISTORY

Reason for Today's Visit: ________________________________ Date of last dental treatment: _________

Former Dentist Name: ____________________ Phone Number: __________________

Check (x) if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Grinding Teeth
- ☐ Sensitivity to hot/cold
- ☐ Bleeding Gums
- ☐ Sores/growth on teeth
- ☐ Periodontal treatment
- ☐ Sensitivity to sweets
- ☐ Food gets caught
- ☐ Clicking/Popping Jaw
- ☐ Sensitivity when biting
- ☐ Dental Implant Failure
- ☐ Tooth Staining

How often do you floss?_______________ How often do you brush?_____________________

How long has it been since your last cleaning?______________ X-rays?__________________

Are you happy with the appearance of your teeth? _____________________________________

MEDICAL HISTORY

Physician's Name:_______________________ Phone#: ________________ Date of last visit: ___________

Have you ever had serious illnesses or operations: ☐ Yes ☐ No If yes, Date: ____________

Specify: ____

Are you pregnant: ______ Is so, how many months? ________ Are you nursing? ________

Check if you have had any of the following:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Addiction
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Shots
- ☐ Diabetes
- ☐ Cough (blood)
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Issues
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Tx
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Ulcer
- ☐ Tuberculosis
- ☐ Venereal Disease

Are you taking any medication? ______ Please list ALL Medications:______________________________

Do you have any drug allergies or have you had any adverse reactions: ☐ Yes ☐ No

If so, please list: ________________________________ ______________________________________

Any additional information regarding your medical history we should know: ________________________