Ira M. Bernstein, DMD, LLC
2 Executive Blvd. Suite 307
Suffern, NY 10901
845-652-5358

WELCOME

Thank you for selecting our office! 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. If you have any questions or need assistance, please ask us, we will be happy to help.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Date_____

Patient's last name:_____First: _____ Middle Initial:_____

SS #_____Date of Birth: _____ Age:_____ Sex: ☐ M ☐ F

Marital status check one: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile Phone:_____

Work Phone:_____ Ext#_____

E-mail:_____

How did you hear about our practice? _____

EMERGENCY CONTACT

Last Name: _____ First:_____

Telephone (☐Mobile ☐Work ☐Home):_____Relationship to patient:_____

PHARMACY

Pharmacy Name: _____ Phone:_____

City:_____State:_____ Zip code:_____

INSURANCE INFORMATION

(Please present your insurance card to be photocopied for our records)

PRIMARY INSURANCE

Subscriber's Name: _____

Relationship to patient: _____

Subscriber's DOB: _____

Subscriber's S.S. #_____

Employer: _____

Employer's phone:_____

Insurance Company_____

ID Number:_____

Group#_____

Ins Provider phone:_____

SECONDARY INSURANCE

Subscriber's Name: _____

Relationship to patient: _____

Subscriber's DOB: _____

Subscriber's S.S. #_____

Employer: _____

Employer phone:_____

Insurance Company_____

ID Number:_____

Group#_____

Ins Provider phone:_____

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment: Cash, Personal Check, Dedicated Healthcare Card

We accept all major credit cards:

VISA MasterCard AMERICAN EXPRESS DISCOVER CareCredit

We request your payment in full at each appointment.

LATE CHARGES:
Any balance over 90 days will be subject to a 1.5% Late Charge. (18% Annual)

AUTHORIZATION AND RELEASE

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/date rates may apply, and I may opt-out at any time by replying STOP

X_____ _____

Patient/Guardian signature Date

PLEASE COMPLETE ALL INFORMATION-THANK YOU

DENTAL HISTORY

Reason for today's visit :_____

Date of last dental visit:_____

Former dentist:_____ **Date of last dental x-rays:**_____

Please check any of the following problems that apply to you.

☐ Sensitivity (hot,cold,sweet)
☐ Tooth pain or discomfort when chewing
☐ Headaches, earaches, neck pain
☐ Jaw joint pain
☐ Teeth or fillings breaking
☐ Grinding or clenching teeth
☐ Bleeding, swollen, or irritated gums
☐ Loose, tipped or shifted teeth
☐ Bad breath or bad taste in your mouth

Do you have or have had any of the following?

☐ Dentures
☐ Partial dentures
☐ Braces
☐ Periodontal (gum) treatment
☐ TMJ treatment
☐ Night Guard (Occlusal guard)
☐ Nitrous Oxide (laughing gas)
☐ Reaction to Novocaine

Please share the following dates:

Your last cleaning _____/_____

Your last oral cancer screening _____/_____

Your last complete set of X-rays _____/_____

	Yes	No
Do you smoke or use chewing tobacco?	☐	☐

How often? _____

	Yes	No
Do you have a history of alcohol or drug abuse?	☐	☐

If you could change your smile, you would:

☐ Make them brighter
☐ Make them straighter
☐ Close spaces
☐ Replace black metal fillings with natural, tooth colored fillings
☐ Repair chipped teeth
☐ Replace missing teeth
☐ Replace old crowns that don't match
☐ Have a smile makeover
☐ Other_____

If you could whiten your teeth for a cost anyone could afford, would you, do it?

_____

On a scale of 1-10, with 10 the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today?

_____

_____

MEDICAL HISTORY

Physician's name_____ Date of last visit_____

Physician's address_____Phone_____

Have you ever been admitted to a Hospital? ☐ Yes ☐ No Have you had any serious illnesses or operations ☐ Yes ☐ No

If Yes, please describe_____

(Women) Are you pregnant ☐ Yes ☐ No Due date_____Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Please check if you have/had:	**Yes**	**No**		**Yes**	**No**
Allergies, hay fever	☐	☐	Infective endocarditis	☐	☐
Anemia	☐	☐	Any immune deficiency	☐	☐
Atrial fib/pacemaker/angina	☐	☐	Liver problem	☐	☐
Angina	☐	☐	Kidney disease	☐	☐
Arthritis, Rheumatism	☐	☐	Joint replacement	☐	☐
Asthma	☐	☐	Osteoporosis, Osteopenia	☐	☐
Breathing or lung problems	☐	☐	Parkinson's Disease	☐	☐
Bulimia, Anorexia	☐	☐	Radiation treatment	☐	☐
Botox, Fillers	☐	☐	Rheumatic fever	☐	☐
Bleeding abnormally with operations or surgery	☐	☐	Sinus trouble	☐	☐
			Sleep apnea/Snoring	☐	☐
Blood disease, clotting disorders	☐	☐	Stroke	☐	☐
Cancer/ Chemotherapy	☐	☐	Transplants		
Congenital heart disease or defect	☐	☐	(kidney, heart, bone marrow)	☐	☐
Cortisone treatments	☐	☐	Thyroid problems	☐	☐
Diabetes	☐	☐	Tuberculosis	☐	☐
Emphysema	☐	☐	Tumor or growth	☐	☐
Epilepsy/Seizures	☐	☐	Ulcer	☐	☐
High/Low blood pressure	☐	☐	Latex allergy	☐	☐

List any other medical issues or history not mentioned above:_____

_____

_____

Allergies to medicines, foods, or other: _____

_____

List of Medications:_____

_____

I certify that I have truthfully filled in the above information and that I will inform the doctor or hygienist at subsequent visits of any changes in my health, including medical and hospital visits and medications.

Patient/Guardian Signature_____ Date_____

Doctor/Hygienist Signature_____ Date_____

(What changes have there been in your medical history; meds, illnesses, doctor visits, hospital)		
Date	**Notes and Changes**	**Initials**