

Welcome

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ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: _____ Age: _____ SS#: _____

Home Address: _____
Apt/Condo # _____

City State Zip

☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed

Hm #: _____ Cell #: _____

Wk #: _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

☐ Previous ☐ Present Dentist: _____

Person Responsible for Account: _____

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SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: _____ Ext: _____ SS #: _____

Birthdate: _____ DL #: _____

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INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

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SCHEDULING POLICY

Our office will do everything possible to schedule an accommodating time for your appointment. We respectfully ask that you provide us with at least 48 hours notice in order to change the appointment. We thank you in advance for this courtesy.

Signature _____

Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____

Date _____

CONTINUED ON BACK

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) ☐ Yes ☐ No

If so, when? _____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

- | | |
|------------------------------------|---------------------------------|
| Y N Abnormal Bleeding/Hemophilia | Y N Herpes / Fever Blisters |
| Y N AIDS | Y N High Blood Pressure |
| Y N Alcohol / Drug Abuse | Y N HIV |
| Y N Anemia | Y N Hospitalized for Any Reason |
| Y N Arthritis | Y N Kidney Problems |
| Y N Artificial Bones/Joints/Valves | Y N Liver Disease |
| Y N Asthma | Y N Low Blood Pressure |
| Y N Blood Transfusion | Y N Lupus |
| Y N Cancer / Chemotherapy | Y N Mitral Valve Prolapse |
| Y N Colitis | Y N Pacemaker |
| Y N Congenital Heart Defect | Y N Psychiatric Problems |
| Y N Diabetes | Y N Radiation Treatment |
| Y N Difficulty Breathing | Y N Rheumatic / Scarlet Fever |
| Y N Emphysema | Y N Seizures |
| Y N Epilepsy | Y N Shingles |
| Y N Fainting Spells | Y N Sickle Cell Disease/Traits |
| Y N Frequent Headaches | Y N Sinus Problems |
| Y N Glaucoma | Y N Stroke |
| Y N Hay Fever | Y N Thyroid Problems |
| Y N Heart Attack / Surgery | Y N Tuberculosis (TB) |
| Y N Heart Murmur | Y N Ulcers |
| Y N Hepatitis | Y N Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

Why have you come to the dentist today?

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change?

Would you like to talk about Invisalign options? ☐ Yes ☐ No

Are you allergic to any of the following?

- | | | |
|------------------------|--------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Penicillin |
| Y N Codeine | Y N Jewelry/Metals | Y N Sulfur |
| Y N Dental Anesthetics | Y N Latex | Y N Tetracycline |

Please list any other drugs/materials that you are allergic to:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature

Date