HENRY A. SACHS, D.D.S.
PERIODONTICS AND IMPLANT DENTISTRY
DIPLOMATE, AMERICAN BOARD OF PERIODONTOLOGY • MEMBER AMERICAN ACADEMY OF IMPLANT DENTISTRY

PATIENT REGISTRATION

Date:_____Phone # _____E-mail_____

Name:_____ Birthdate _____ Age _____

Address:_____

City: _____ State: _____Zip:_____ SS#_____

Occupation: _____ Spouse's Name:_____

Employer: _____ Business Phone#_____

Emergency contact name and phone number _____

If Referred, by whom? ____ My Dentist Other_____

Your Dentist's Name: _____ Phone #_____

Address: _____State: _____ Zip:_____

Your Physician's Name: _____ Phone #_____

Address: _____State: _____ Zip:_____

What is your chief concern? : _____

Your Pharmacy? Name:_____ Tel:_____ Address:_____

Do You Require Nitrous Oxide for Treament?:_____

DENTAL INSURANCE INFORMATION

Subscriber's Name: _____ Birthdate: _____

Employer: _____ Soc. Sec.#_____

Insurance Co. _____ Group No._____

Deductible:_____ Maximum Annual Benefit: _____

Relationship to subscriber ____Self ____Spouse ____Child ____Other_____

SECONDARY DENTAL INSURANCE PLAN (if applicable)

Subscriber's Name:_____ Birthdate: _____

Employer: _____ Soc. Sec.#_____

Insurance Co._____ Group #_____

1181 Old Country Road - Suite 2, Plainview, NY 11803 • Tel. (516) 932-3050 • Fax: (516) 932-0911

Patient Medical History

PHYSICIAN_____ OFFICE PHONE _____DATE OF EXAM _____

	YES	NO
1. Are you under medical treatment now?	❑	❑
2. Have you been hospitalized for any surgical operation or serious illness in the past 5 years?	❑	❑
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑
a. If yes, what medication(s) are you taking?	❑	❑
b. Do you need to take antibiotics before treatment?	❑	❑
4. Do you use tobacco?	❑	❑
5. Do you use alcohol, cocaine or other drugs?	❑	❑
6. Are you wearing contact lenses?	❑	❑
	❑	❑

7. Are you allergic to or have you had any reactions to the following?

	YES	NO		YES	NO		YES	NO
Local anesthetics (eg . novocaine)	❑	❑	Barbiturates	❑	❑	Aspirin	❑	❑
Penicillin or other antibiotics	❑	❑	Sedatives	❑	❑	Other	❑	❑
Sulfa Drugs	❑	❑	Iodine	❑	❑		❑	❑

8. WOMEN ONLY

	YES	NO
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking birth control pills?	❑	❑

9. Do you have or have you ever had any of the following:

YES	NO		YES	NO		YES	NO	
❑	❑	High Blood Pressure	❑	❑	Heart Disease	❑	❑	Chest Pains
❑	❑	Heart Attack	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded
❑	❑	Rheumatic Fever	❑	❑	Heart Murmur	❑	❑	Stroke
❑	❑	Swollen Ankles	❑	❑	Angina	❑	❑	Hay Fever/Allergies
❑	❑	Fainting/Seizures	❑	❑	Frequently Tired	❑	❑	Tuberculosis
❑	❑	Asthma	❑	❑	Anemia	❑	❑	Radiation Therapy
❑	❑	Low Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma
❑	❑	Epilepsy/Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss
❑	❑	Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease
❑	❑	Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Heart Trouble
❑	❑	Kidney Diseases	❑	❑	Hepatitis/Jaundice	❑	❑	Respiratory Problems
❑	❑	AIDS or HIV Infection	❑	❑	Sexually Transmitted Disease	❑	❑	Other
❑	❑	Thyroid Problem	❑	❑	Stomach Problems/Ulcers			

	YES	NO
10. Are you feverish?	❑	❑
11. In the last 21 days have you been to Sierra Leone, Liberia or Guinea?	❑	❑

PATIENT DENTAL HISTORY

	YES	NO		YES	NO
1. Do your gums bleed while brushing or flossing?	❑	❑	8. Do you have frequent headaches?	❑	❑
2. Are you sensitive to hot or cold liquids/foods?	❑	❑	9. Do you clench or grind your teeth?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑	10. Do you bite your lips or cheeks frequently?	❑	❑
4. Do you feel pain in any of your teeth?	❑	❑	11. Have you ever had any difficult extractions in the past?	❑	❑
5. Do you have sores or lumps in or near your mouth?	❑	❑	12. Have you had any orthodontic work?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑	13. Have you ever had prolonged bleeding following extractions?	❑	❑
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?	❑	❑
a) Clicking?	❑	❑	15. Have you ever had instruction for the care of your gums?	❑	❑
b) Pain (joint, ear, side or face?)	❑	❑		❑	❑
c) Difficulty in opening or closing?	❑	❑		❑	❑
d) Difficulty chewing?	❑	❑		❑	❑

I certify that I have read and understand the above information and 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.

SIGNATURE **X**_____ _____

Patient, Parent or Guardian **Date**