DR. TERESE N. FAY, DMD, PLLC
MANHATTAN DENTISTRY

20 East 46th Street, Suite 1003, New York, NY 10017

212.759.1383

Date: _____

Patient Information

Patient Name: _____
Last First MI

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Whom may we thank for referring you to our practice? _____

If not referred by a patient, please let us know how you heard about us. _____

Emergency Contact Information

Name: _____ Phone #: _____ Relationship to Patient: _____

Insurance Information

Primary Insurance Carrier: _____ Insurance Company Phone Number: _____ Group #: _____

Subscriber's Employer Name: _____ Subscriber's ID # or SSN: _____

✶ Patient's relationship to the insured: Spouse ☐ Child ☐ Other ☐

If subscriber is other than patient, Subscriber's Name: _____ Birth Date: _____
Last First MI

Do you have secondary insurance? YES ☐ NO ☐ If yes, Insurance Carrier's Name? _____

Subscriber's Name: _____ Birth Date: _____ ID # or SSN: _____

Consent for Services

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits or credit information. I authorize payment of insurance benefits directly to Terese N. Fay, DMD, PLLC, otherwise payable to me. **I have read the above conditions and agree to their content.**

⇨ _____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Privacy Practices Acknowledgement – HIPAA

I understand that Terese N. Fay, DMD, PLLC strictly adheres to the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") in order to protect my privacy as a patient. As a patient, I understand that my information can be used to conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly. It may also be used to obtain payment from the third party payers or conduct normal healthcare operations such as quality assessments and physician certifications. I understand that if I would like to read a detailed Notice of Privacy Practices, I may request to see one at any time and one will be furnished. I may also view a copy online at www.faydentistry.com.

⇨ _____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

MEDICAL HISTORY

Name of Physician/and their specialty _____ Phone#: _____

Date of most recent physical examination _____ Purpose _____

Are you aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)? YES ☐ NO ☐

If yes, discuss _____

Have you ever been hospitalized? YES ☐ NO ☐ If yes, discuss _____

Have you ever had a serious injury to your head or neck? YES ☐ NO ☐ If yes, discuss _____

DO YOU HAVE or HAVE YOU EVER HAD:

YES NO

HEART

- ☐ ☐ Heart Trouble/ Disease
- ☐ ☐ Heart Murmur
- ☐ ☐ Arrhythmia
- ☐ ☐ Angina/ Chest Pain
- ☐ ☐ Heart Attack/ Failure
- ☐ ☐ Congenital Heart Disorder
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Damaged or Artificial Heart Valve
- ☐ ☐ Heart Pace Maker or Stent
- ☐ ☐ Heart Surgery
- ☐ ☐ High or Low Blood Pressure
- ☐ ☐ Aneurysm
- ☐ ☐ History of Infective Endocarditis
- ☐ ☐ Arteriosclerosis
- ☐ ☐ High Cholesterol

BLOOD

- ☐ ☐ Blood Disease or Disorder
- ☐ ☐ Bruise Easily
- ☐ ☐ Anemia
- ☐ ☐ Excessive Bleeding
- ☐ ☐ Recent Blood Transfusion

YES NO

LUNGS

- ☐ ☐ Lung Disease
- ☐ ☐ Breathing or Sleep Problems (i.e. sleep apnea, snoring)
- ☐ ☐ Shortness of Breath
- ☐ ☐ Frequent Cough
- ☐ ☐ Hay Fever
- ☐ ☐ Sinus Trouble
- ☐ ☐ Asthma
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Tuberculosis

CANCER

- ☐ ☐ Cancer
- ☐ ☐ Tumor/ Abnormal Growth
- ☐ ☐ X-ray Treatments (Radiation)
- ☐ ☐ Chemotherapy

GSTRO-INTESTIONAL

- ☐ ☐ Stomach/ Intestinal Disease
- ☐ ☐ Digestive Disorders (i.e. celiac disease, irritable bowel)
- ☐ ☐ Ulcers
- ☐ ☐ Hernia
- ☐ ☐ Acid Reflux
- ☐ ☐ Recent Weight Loss

YES NO

- ☐ ☐ Diabetes
- ☐ ☐ Excessive Thirst
- ☐ ☐ Hypoglycemia

LIVER

- ☐ ☐ Liver Disease
- ☐ ☐ Hepatitis A (Infectious)
- ☐ ☐ Hepatitis B or C
- ☐ ☐ Jaundice
- ☐ ☐ Alcoholism

KIDNEY

- ☐ ☐ Kidney Disease
- ☐ ☐ Renal Dialysis
- ☐ ☐ Kidney Stones
- ☐ ☐ Urinary Tract Infections

ENDOCRINE

- ☐ ☐ Thyroid Disease
- ☐ ☐ Parathyroid Disease
- ☐ ☐ Hormone Deficiency
- ☐ ☐ Prostate Disorders

AUTOIMMUNE/BONE

- ☐ ☐ Autoimmune Disease
- ☐ ☐ Arthritis/ Gout
- ☐ ☐ Rheumatism
- ☐ ☐ Lupus
- ☐ ☐ Allergies (Pollen/Dust)
- ☐ ☐ Hives or Rash

YES NO

- ☐ ☐ Persistent Swollen Neck Gland or Lymph Nodes
- ☐ ☐ Organ Transplant
- ☐ ☐ Osteoporosis/Osteopenia
- ☐ ☐ Artificial Joints
- ☐ ☐ Pain in Jaw Joint
- ☐ ☐ Cortisone/Steroid Therapy

INFECTION

- ☐ ☐ HIV Positive
- ☐ ☐ STI / STD / HPV
- ☐ ☐ Herpes, Cold Sores, Fever Blisters

BRAIN

- ☐ ☐ Stroke
- ☐ ☐ Epilepsy or Seizures
- ☐ ☐ Fainting or Dizziness
- ☐ ☐ Neurologic disorders
- ☐ ☐ Migraines
- ☐ ☐ Glaucoma, Contact lens
- ☐ ☐ Nervousness
- ☐ ☐ Emotional Difficulties
- ☐ ☐ Psychiatric Care
- ☐ ☐ Frequent Headaches
- ☐ ☐ Alzheimer's Disease

Any other medical conditions not checked above? YES ☐ NO ☐ If yes, discuss _____

List all **medications, supplements, and or vitamins** taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____

Have you had an **allergic reaction** to: ☐ Aspirin ☐ Sulfa ☐ Acetaminophen ☐ Local Anesthetic ☐ Penicillin ☐ Fluoride ☐ Tetracycline ☐ Latex ☐ Ibuprofen ☐ Acrylic ☐ Codeine ☐ Metals (Nickel, Gold, Silver) ☐ Erythromycin ☐ Other _____

Women (please check): ☐ Pregnant/ trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives?

Social Habits:

Do you use tobacco in any form? ☐ If so, what type? _____How much/ many packs per day? _____

Do you use recreational drugs? ____ If so, which ones and how much? _____

Number of sodas or sweet drinks per day? _____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.
To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

⇨ _____ Date _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Reviewed by Doctor_____ Date _____ BP _____