Steven Glassman, D.D.S. • Debra C. Glassman, D.D.S.
160 West End Avenue, #1-R New York, NY 10023 • (212) 787-4860

PERSONAL INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME TELEPHONE: _____ OFFICE TELEPHONE: _____

CELLULAR TELEPHONE: _____ FAX: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

OCCUPATION: _____

PREFERENCES

How would you like us to remind you about your appointments?

☐ Via Telephone (please note the best number) ☐ Via Fax ☐ Via Email

What are your appointment preferences?

Day of the Week: _____ ☐ Morning ☐ Afternoon ☐ After 5:00 p.m.

Please list/check which accommodations you prefer:

Your choice of Music: _____ Your choice of DVD:_____

Your choice of Cable TV Channel: _____ Your choice of beverage:_____

☐ Massage pad of chair ☐ Paraffin Gloves

What reviews sites and services do you belong to?

☐ Google Places ☐ Yelp ☐ Judy's Book ☐ Facebook ☐ Yahoo

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We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our **"Financial Policy" is important to our professional relationship. Please ask if you have any questions about our fees, "Financial Policy," or your responsibility.**

**ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DOCTOR

** FULL PAYMENT IS DUE AT TIME OF SERVICE

**WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AND AMERICAN EXPRESS

**THIRD-PARTY FINANCING OPTIONS ARE AVAILABLE

**RETURNED CHECKS ARE SUBJECT TO A SERVICE CHARGE AND CANNOT BE REDEPOSITED

**CHARGES WILL BE MADE FOR BROKEN APPOINTMENTS THAT ARE CANCELLED WITHOUT ONE FULL BUSINESS DAY'S NOTICE

INSURANCE
If you have dental insurance we will help you receive maximum allowable benefits. We will help you complete claim forms so that you can be reimbursed by your insurance company to the extent of your coverage. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

THE PATIENT IS FULLY RESPONSIBLE FOR THE ACCOUNT. If you have any questions about the above information or are uncertain regarding insurance information, PLEASE do not hesitate to ask. WE AREHERE TO HELP.

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PRIVACY

I hereby authorize Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs. I also authorize Doctor to publish the aforementioned materials for proprietary Glassman Dental Care marketing purposes, provided I give my consent prior to publication. I also authorize Doctor to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon.

I further authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the filling and reimbursement of insurance benefits for which I am entitled.

"I understand and agree that I am responsible for my account and agree to pay at the time of services rendered. I have read and agree to all the information on this sheet."

NAME (please print) _____ DATE _____

SIGNATURE _____ DATE _____

PARENT OR GUARDIAN (of minor) _____ DATE _____

MEDICAL HISTORY

Patient Name_____ Nickname_____ Age _____

Name of Physician_____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Poor ☐ Fair ☐ Good ☐

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury	☐	☐
2. allergic reaction to		
☐ aspirin, ibuprofen, acetomenophen		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ codeine		
☐ local anesthetic		
☐ fluoride		
☐ metals (gold, stainless steel)		
☐ latex		
☐ any other medications _____		
3. heart problems	☐	☐
4. heart murmur	☐	☐
5. rheumatic fever	☐	☐
6. scarlet fever	☐	☐
7. high blood pressure	☐	☐
8. low blood pressure	☐	☐
9. a stroke	☐	☐
10. artificial prosthesis (i.e. heart valve or joints)	☐	☐
11. anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut	☐	☐
13. emphysema	☐	☐
14. tuberculosis	☐	☐
15. asthma	☐	☐
16. sinus problems	☐	☐
17. kidney disease	☐	☐
18. liver disease	☐	☐
19. jaundice	☐	☐
20. thyroid or parathyroid disease	☐	☐
21. hormone deficiency	☐	☐
22. high cholesterol	☐	☐
23. diabetes	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. digestive disorders	☐	☐

	YES	NO
26. arthritis	☐	☐
27. glaucoma	☐	☐
28. contact lenses	☐	☐
29. head or neck injuries	☐	☐
30. epilepsy, convulsions (seizures)	☐	☐
31. viral infections and cold sores	☐	☐
32. any lumps or swelling in the mouth	☐	☐
33. hives, skin rash, hay fever	☐	☐
34. venereal disease	☐	☐
35. hepatitis (type _____)	☐	☐
36. HIV / AIDS	☐	☐
37. tumor, abnormal growth	☐	☐
38. radiation therapy	☐	☐
39. chemotherapy	☐	☐
40. emotional problems	☐	☐
41. psychiatric treatment	☐	☐
42. antidepressant medication	☐	☐
43. alcohol / drug dependency	☐	☐
ARE YOU:		
44. presently being treated for any illness	☐	☐
45. aware of a change in your general health	☐	☐
46. often exhausted or fatigued	☐	☐
47. subject to frequent headaches	☐	☐
48. a heavy smoker (1 pack or more a day)	☐	☐
49. considered a touchy person	☐	☐
50. often unhappy or depressed	☐	☐
51. easily upset or irritated	☐	☐
52. FEMALE - taking birth control pills	☐	☐
53. FEMALE - pregnant	☐	☐
54. MALE - Prostate disorders	☐	☐

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment _____

_____

List any medications, herbal supplements, and or vitamins taken within the last two years_____

_____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature_____ Date_____

Doctor's Remarks: _____

_____ Doctor's Signature_____

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DENTAL HISTORY

Referred by _____

Previous dentist _____ How long _____

Most recent dental exam _____ Most Recent dental x-ray _____

Most recent dental treatment _____

How often do you have your teeth cleaned? 3 mo ☐ 4 mo. ☐ 6 mo. ☐ 1 year or longer ☐

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
1. unhappy with the appearance of your teeth	☐	☐
2. unfavorable dental experiences	☐	☐
3. dental fears	☐	☐
4. problems with effectiveness or bad reactions to dental anesthetic	☐	☐
5. orthodontic treatment (braces) when	☐	☐
6. periodontal (gum) treatment when	☐	☐
7. bleeding gums	☐	☐
8. avoid brushing any part of your mouth	☐	☐
9. part of your mouth is sensitive to temperature	☐	☐
10. sore teeth	☐	☐
11. a burning sensation in your mouth	☐	☐
12. difficulty swallowing	☐	☐
13. an unpleasant taste or odor in your mouth	☐	☐
14. dry mouth, throat, and or eyes	☐	☐
15. jaw problems (temporomandibular joint)	☐	☐
16. difficultly opening your mouth widely	☐	☐
17. stiff neck muscles	☐	☐
18. awaken with an awareness of your teeth or jaws	☐	☐
19. tension headaches	☐	☐
20. clench or grind your teeth	☐	☐
21. jaw clicking or popping	☐	☐
22. lost any teeth	☐	☐
23. do you sweat or tremble a lot during examination	☐	☐
24. do strange people or places make you afraid	☐	☐

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES	NO	(Please check Yes or No)
☐	☐	Has your present denture been relined? When _____
☐	☐	Is your present denture a problem? Describe _____
☐	☐	Satisfied with the appearance? _____
☐	☐	Satisfied with the comfort? _____
☐	☐	Satisfied with the chewing ability? _____
		When did you receive your first partial or complete denture? _____
		How long have you worn your present denture? _____

Patient's Signature _____ Date _____

Doctor's Remarks: _____

_____ Doctor's Signature _____

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