Dr. Ralph Kaye

Patient Name _____ Date _____
Last Name First Name Middle Initial

SS/HIC/Patient ID # _____ Sex ❑ Male ❑ Female

Address _____

City _____ State _____ Zip _____

PATIENT INFORMATION

Email _____

Birthdate _____ ❑ Married ❑ Widowed ❑ Single

❑ Divorced ❑ Separated ❑ Minor ❑ Partnered for _____ years

Address _____

City _____ State _____ Zip _____

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ **SS#** _____

Spouse's Employer _____

Check which number is best to reach you. Best time? _____

❑ Home Phone (_____) _____

❑ Work Phone (_____) _____ Ext. _____

❑ Cell Phone (_____) _____

EMERGENCY CONTACT (Specify someone who does not live in your household)

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____ Ext. _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Employer _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____

Birthdate _____ **SS#** _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or dependent(s), have insurance coverage with

_____ and assign directly to Dr. Ralph Kaye all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all the charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____
Date Relationship to Patient

DENTAL HISTORY

Reason for today's visit _____

_____

Referring Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

Check YES or NO to indicate if you have had any of the following:

Bad breath	❑ Yes ❑ No	Burning sensation on tongue	❑ Yes ❑ No	Mouth breathing	❑ Yes ❑ No
Bleeding gums	❑ Yes ❑ No	Chew on one side of mouth	❑ Yes ❑ No	Mouth pain, brushing	❑ Yes ❑ No
Blisters on lips or mouth	❑ Yes ❑ No	Cigarette, pipe, or cigar smoking	❑ Yes ❑ No	Orthodontic treatment	❑ Yes ❑ No
		Clicking or popping jaw	❑ Yes ❑ No	Pain around ear	❑ Yes ❑ No
		Dry mouth	❑ Yes ❑ No	Family history of gum disease	❑ Yes ❑ No
		Fingernail biting	❑ Yes ❑ No	Periodontal treatment	❑ Yes ❑ No
		Food collection between teeth	❑ Yes ❑ No	Sensitivity to cold	❑ Yes ❑ No
		Foreign objects	❑ Yes ❑ No	Sensitivity to heat	❑ Yes ❑ No
		Grinding teeth	❑ Yes ❑ No	Sensitivity to sweets	❑ Yes ❑ No
		Gums swollen or tender	❑ Yes ❑ No	Sensitivity when biting	❑ Yes ❑
		Jaw pain or tiredness	❑ Yes ❑ No	Sores or growths in mouth	❑ Yes ❑ No
		Lip or cheek biting	❑ Yes ❑ No	How often do you floss? _____	
		Loose teeth or broken filings	❑ Yes ❑ No	How often do you brush? _____	

Patient Name _____ Date_____
Last Name First Name Middle Initial

HEALTH HISTORY

Physician's Name _____ Physician's Phone (_____) _____

Date of last visit _____

Have you ever taken any of the group of drugs referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexofenfluramine) ❑ Yes ❑ No

Check YES or NO to indicate if you have had any of the following:

AIDS/HIV	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Fainting or dizziness	❑ Yes ❑ No	Respiratory Disease	❑ Yes ❑ No
Arthritis, Rheumatism	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Artificial Joints	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Heart Problems	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Back Problems	❑ Yes ❑ No	Hepatitis Type _____	❑ Yes ❑ No	Skin Rash	❑ Yes ❑ No
Bleeding abnormally with extraction		Herpes	❑ Yes ❑ No	Special Diet	❑ Yes ❑ No
or surgery	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No	Swollen Feet or Ankles	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Jaw Pain	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Circulatory Problems	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Tumor or growth on head or neck	
Congenital Heart Lesions	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No		❑ Yes ❑ No
Cortisone Treatments	❑ Yes ❑ No	Nervous Problems	❑ Yes ❑ No	Ulcer	❑ Yes ❑ No
Cough, persistent or bloody	❑ Yes ❑ No	Osteoporosis or Osteopenia	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Weight Loss, unexplained	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No		

Do you wear contacts? ❑ Yes ❑ No

Women

Are you pregnant? ❑ Yes ❑ No Due Date_____

Taking birth control pills? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

MEDICATIONS

List any medications you are currently taking and the corresponding diagnosis:

_____

_____

_____

ALLERGIES

❑ Aspirin ❑ Local Anesthetic

❑ Barbiturates (Sleeping Pills) ❑ Penicillin

❑ Codeine ❑ Sulfa

❑ Iodine ❑ Other _____

❑ Latex _____

PHARMACY

For the office to send your prescription(s) to your pharmacy, this area **MUST be completed in full**.

Pharmacy Name _____

Pharmacy Phone (_____) _____ Pharmacy Address _____

Patient's Signature _____Date_____