

LONG ISLAND
SMILE
Cosmetic & Restorative Dentistry
Snoring & Sleep Apnea Treatment

Dear New Patient,

We would like to take this opportunity to welcome you to our practice. We are looking forward to seeing you at your first appointment. Please fill out the enclosed forms and have them completed when you come in. The information on these forms is necessary to provide you with the best dental care possible. If you do have dental insurance, we ask that you bring in the necessary forms and insurance information so that we can assist you in preparing and submitting the dental forms, and help maximize your benefits. If you could send us the insurance information ahead of time, that would also be helpful.

The initial appointment (except in cases of emergencies) is spent conducting a thorough examination. This includes a complete health history, a visual examination of the mouth tissues and teeth, and necessary x-rays and diagnostic models when necessary. We will then diagnose your case so that on your next visit we can discuss the conditions present in your mouth and recommend proper treatment. Fees for the recommended services are outlined and financial arrangements are made at this appointment.

The treatment room will be reserved for you at the time you specify as most convenient. If for some unforeseen reason you find it impossible to keep a scheduled appointment please let us know at least 24 hours in advance so that another patient may use the time that has been reserved for you.

Should you have an emergency problem, please contact our office immediately. We will be sure to see you as soon as possible.

If you have any questions, please feel free to discuss them with any member of our staff. They are here to help you. Again, we welcome you to our dental practice and look forward to meeting you.

Sincerely,

Jeffrey S. Rein, DDS
Neal Seltzer, DMD

Neal Seltzer, D.M.D., F.A.G.D. ☺ Jeffrey S. Rein, D.D.S., F.A.G.D.
Diplomates, American Board of Dental Sleep Medicine

PATIENT REGISTRATION

Last Name _____ First Name _____ Middle Initial _____

Salutation: Mr. Mrs. Ms. Dr. Other: _____

What do you like to be called _____

Date of Birth _____ Social Security # _____

Sex _____ Marital Status: Single Married Partnered Widowed Divorced

Home Address _____ Apt. _____ City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____ ext. _____

Cell _____ Pager _____ Email _____

How would you prefer to be contacted? Home tel. Work tel. Cell e-mail Text message

Occupation _____ Employer _____

Student Yes (Full time Part time) No (Name of School) _____

Do you have a preferred appointment time (day and/or time)? _____

Emergency Contact _____ Phone _____

Whom may we thank for referring you? _____

Do we treat any other members of your family? _____

Are there any family members you prefer to have listed on a separate account Yes No List _____

The purpose of my visit is _____

If you have dental benefits, please provide the following information.

Employer _____ Address _____

Insurance Company _____ Address _____

Policy Number _____ Group Number _____ ID Number of Insured _____

If you have dental benefits through a family member please provide the following information.

Name of Insured: Last _____ First _____ Middle Initial _____

Date of Birth of Insured _____ Relationship to Insured _____ S.S. Number of Insured _____

Policy Number _____ Group Number _____ ID Number of Insured _____

Employer _____ Address _____

Insurance Company _____ Address _____

If patient is a minor or someone other than the patient is responsible for the account, please provide the following information.

If dependent child: Father's Birthdate _____ Mother's Birthdate _____

Name of responsible Party _____ Relationship _____ Tel. _____

Street Address _____ Apt. _____ City _____ State _____ Zip _____

Signature of guardian (for patients under eighteen) _____ Date _____

To the best of my knowledge, the questions on this form have been accurately answered.

Signature of Patient _____ Date _____

Signature of Parent, or Guardian _____ Date _____

MEDICAL HISTORY

PATIENT NAME: _____

DATE OF BIRTH: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

Are you under a physician's care now? yes no

If yes, please explain: _____

Have you ever been hospitalized or had a major operation? yes no

If yes, please explain: _____

Are you taking any medications, pills, or drugs? yes no

If yes, please explain: _____

Do you take, or have taken, Phen-Fen or Redux? yes no

Are you on a special diet? yes no

Do you use tobacco? yes no

Do you use controlled substances? yes no

Do you take, or have taken Boniva, Fosamax, Actonel or any other medication for osteoporosis? yes no

Women: Are you

Pregnant/Trying to get pregnant? Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Aids/HIV Positive | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tired |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Tumor or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Shingles | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sinus Trouble | |

Have you ever had any serious illness that is not listed above? yes no If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient _____ Date _____

Signature of Parent, or Guardian _____ Date _____

DENTAL HISTORY

Patient Name: _____

Date of Birth: _____

What is the reason for your visit today _____

Date of last dental visit _____ Last cleaning _____

Last full mouth X-rays _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____

How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, ect.) _____

Do you have any dental problems now? Yes No

If yes, please describe _____

Are any of your teeth sensitive to:

- Hot or cold? Yes No
- Sweet or sour liquids? Yes No
- Biting or Chewing? Yes No
- Have you noticed any mouth odors or bad tastes? Yes No
- Do you frequently get cold sores, blisters, lumps or any other oral lesions? Yes No

Do you:

- gums bleed or hurt? Yes No
- Have your parents experienced gum disease or tooth loss? Yes No
- Have you noticed any loose teeth or change in your bite? Yes No
- Does food tend to become caught in between your teeth? Yes No
If yes, where? _____

Do you:

- Clench or grind your teeth while awake or asleep? Yes No
- Bite your lips or cheeks regularly Yes No
- Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No
- Mouth breathe while awake or asleep? Yes No
- Have tired jaws, especially in the morning? Yes No

Have you ever had:

- Orthodontic treatment? Yes No
- Oral surgery? Yes No
- Difficult extraction? Yes No
- Periodontal treatment? Yes No
- Prolonged bleeding following extractions? Yes No
- Your teeth ground or the bite adjusted? Yes No
- A bite plate or mouth guard? Yes No
- A serious injury to the mouth or head? Yes No
If so, please describe, including cause _____

Have you experienced:

- Clicking or popping of the jaw? Yes No
- Pain? (joint, ear, side of face, teeth) Yes No
- Difficulty in opening or closing the mouth? Yes No
- Difficulty in chewing on either side of the mouth? Yes No
- Headaches, neckaches or shoulder aches? Yes No
- Sore muscles (neck, shoulders)? Yes No
- Have you ever had instruction on the correct method of brushing your teeth? Yes No
- Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

• Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Cosmetics:

- Do you like the appearance of your teeth, your smile? Yes No
- Are your teeth all in alignment (straight)? Yes No
- Do you have spaces you don't like? Yes No
- Do you like the color of your teeth? Yes No
- Do you like the shape of your teeth? Yes No
- Are your teeth chipped protruding hidden
- Have you used any tooth whitening products? Yes No
- Do you like the way your teeth come together? Yes No
- Are there old silver fillings or dental treatment that your don't like looking at? Yes No

• What would you like to change the most in appearance of your teeth _____

• How would you like your teeth to look? _____

Comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient _____ Date _____

Signature of Parent, or Guardian _____ Date _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

✓ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>Total Score: _____</p> <p>(Add columns 0-3)</p>
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Patient Signature _____

Date _____

FINANCIAL AGREEMENT

Name of patient: _____

Name of person responsible for payment: _____

Relation to patient: _____

I understand that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. If assignment of dental benefits are made, I will be immediately responsible for any co-payments. If my insurance does not cover any part of my dental treatment because of limitations, deductions or loss of coverage I will become responsible for all fees rendered and agree to pay these fees immediately. I also agree that if I suspend or terminate my care and treatment, any fees rendered to me will be immediately due and payable. Additionally it is agreed that should the fee for professional services not be paid in accordance with the provisions herein, there shall be included in the computation of the amount due, an amount of reasonable attorney's fees in any collection proceedings as well as all disbursements, allowances and costs provided by law.

Payment is expected at the time of visit unless other arrangements are made in advance. Patients may be charged for a "NO-SHOW". These are broken appointments with no courtesy call of cancellation.

Patient signature (if 18 years or older)

Date

Signature: (circle one) Parent, Spouse, Guardian

Date