Tooth Fairy World, PC (Hyde Park) - 11/1/2023

Patient Information

Patient Information

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Middle Name	Gender	Marital Status	Address
City	State	Zip	Birthdate
E-mail	Social Security #	Home Phone	Cell Phone

Employment Information

Is the patient employed?

Work Phone	Employer	Occupation	No. Years Employed

Spouse/Additional Contact Information

Spouse/Additional Contact First Name		Spouse/Additional Contact Last Name	
Address	City	State	Zip
Birthdate	E-mail	Relationship to Patient	
Home Phone	Cell Phone	Work Phone	Employer
Occupation		No. Years Employed	

Insurance Information

Primary Insurance

Does the patient have insurance?

Policy Owner's Name	Policy Owner's Social Security #
Policy Owner's Birthdate	Relationship to Patient
Policy Owner's Employer	Insurance Company Name
Member ID	Group No. (plan, local, or policy)
Insurance Company Phone	

Secondary Insurance

Does the patient have additional insurance?

Policy Owner's Name	Policy Owner's Social Security #
Policy Owner's Birthdate	Relationship to Patient
Policy Owner's Employer	Insurance Company Name
Member ID	Group No. (plan, local, or policy)
Insurance Company Phone	

Medical and Dental History

Medical History

Are you under the care of a physician?

If yes, please explain:	Physician	Phone
Last Visit		
Address		

Pregnancy

Are you or might you be pregnant?

If so, how many weeks?

Dental History

Have your tonsils or adenoids been removed?	Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)?	Do you have any missing or extra permanent teeth?

Have you ever had an injury to: (select all that apply)

Teeth	Mouth	Chin	Do you have speech problems?
Do your gums bleed?	Do you smoke?	Do you like your smile?	

Dental Habits

Do/have you have/had any of the following habits?

Clenching/Grinding Teeth	Lip Sucking/Biting	Mouth Breather	Nail Biting
Thumb/Finger Sucking	Prolonged Bottle/Pacifier	Tongue Thrusting	

Allergies

Are you allergic to any of the following?

Aspirin	Any Metals/Plastics	Latex	Penicillin

Codeine	Erythromycin	Tetracycline

Other Allergies/Sensitivities:

Medications

Are you currently taking any medications?

List all drugs you are currently taking:

Medication Condition(s)

Please list any serious medical condition(s) treated:

Certification

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I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this officce of any changes in my medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office. I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form

Signature

Date