Welcome To Our Office

DENTAL ARTS GROUP EST. 1960

Barry S. Pinsky, D.D.S. Ellen B. Folbe, D.D.S.
and Associates

Patient Last Name _____ First _____ Initial _____

(❑ Single ❑ Married ❑ Divorced ❑ Widowed) (❑ Male ❑ Female) Birthday: Month_____ Day_____ Year_____

Address_____ City_____ State_____ Zip_____

Telephone (Home)_____ (Cell)_____

Email address_____ (Work)_____ ext._____

Pharmacy:_____ Pharmacy phone #:_____

Employer_____ Position/Dept. _____

SS#_____ Driver's Lic.# _____

Dental Insurance Co._____ Group & ID# _____

Spouse or Responsible Party (If Other Than Patient)

Last Name _____ First _____ Initial _____

Address_____ Birthday: Month_____ Day_____ Year _____

City_____ State_____ Zip_____

Telephone (Home)_____ (Cell)_____ (Work)_____ ext.

Employer_____ SS# _____

Dental Insurance Co._____ Group & ID# _____

Nearest Relative (In Case of Emergency)

Last Name _____ First _____ Initial _____

Address_____ Birthday: Month_____ Day_____ Year _____

City_____ State_____ Zip_____

Telephone (Home)_____ (Cell)_____ (Work)_____ ext._____

Has any member of your family ever been treated in our office? ❑ Yes ❑ No

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

Privacy Notice to Our Patients

Privacy Notice is available at your request. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Signature_____

Name of your physician_____ Phone No. _____

Date of Last Physical Examination _____

Are you currently being treated for any medical condition? _____

If so, for what? _____

MEDICAL HISTORY

Do You Have or Have You Ever Had Any Of The Following?

Anemia	YES	NO
Diabetes	YES	NO
Epilepsy/Seizures	YES	NO
Hepatitis	YES	NO
Tuberculosis	YES	NO
Sinus Trouble	YES	NO
Frequent or severe headaches	YES	NO
History of Ulcers	YES	NO
HIV + /(AIDS)	YES	NO
Herpes	YES	NO
Asthma	YES	NO
Psychiatric Treatment	YES	NO
Injury to Face or Jaw	YES	NO
Tendency To Faint	YES	NO
Rheumatism/Arthritis	YES	NO
Cancer Treatment (Radiation Therapy)	YES	NO
Respiratory Illness/COPD	YES	NO

Allergies To:

Local Anesthetic	YES	NO
Medication or Drugs	YES	NO
Penicillin	YES	NO
Latex	YES	NO
Food Allergies	YES	NO

Have you ever taken or are you currently taking an antiresorptive agent or biophosphonate (like Fosomax, Actonel, Zometa, Boniva, Reclast, Aredia, Prolia) for osteoporosis or Paget's disease?	YES	NO
Heart Attack/Stroke	YES	NO
Heart Surgery	YES	NO
Pacemaker	YES	NO
Abnormal Heart Condition	YES	NO
High or Low Blood Pressure	YES	NO
Tendency to Bleed	YES	NO
Chest Pain on Exertion	YES	NO
Kidney Treatment	YES	NO
Have You Ever Used Any Form of Tobacco?	YES	NO

Dental Procedures that may Require Premedication

History of Infective Endocarditis?	**YES**	**NO**
Artificial (prosthetic) Heart Valve	**YES**	**NO**
Replacement Surgery (joint/hip, knee etc)	**YES**	**NO**
Bone Marrow Transplant	**YES**	**NO**

Date of Surgery_____

Women:

Are you pregnant now?	**YES**	**NO**
Are you nursing now?	**YES**	**NO**
Do you take birth control pills?	**YES**	**NO**

If allergies to medication or drugs, indicate which ones _____

Are you taking any medications?_____ **If so, which ones** _____

_____

I, _____ authorize the following individual to speak with Dr. Folbe, Associates and staff on my behalf, regarding dental treatment, appointments, and fees. I also confirm that I am 18 years or older and have the right to authorize access to this patient's records.

Authorized User's Name (s) _____

Authorized User's Telephone _____Relationship to Patient_____

Authorization

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.I hereby authorize the attending dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I authorize the release of information related to patient treatment, payment, or health care operations.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

Please note that you are responsible for the payment of charges not covered by insurance.
Payment due at time of service.
A fee of $35.00 will be charged for each returned check.