ALLEN F. AVRUTIN, D.D.S., F.A.G.D.
JERRY L. STATMAN, D.M.D., F.A.G.D.
105-107 Theodore Fremd Avenue • Rye, NY 10580 • 914-967-0707
www.ryefamilydentistry.com

Patient Information (Confidential)

Referred By: _____

Name (Dr.) (Mr.) (Mrs.) (Ms.) _____ Date _____

Soc. Sec. # _____ Birthdate _____ Home Phone _____

Cell Phone # _____ E-mail Address _____

Address _____ City _____ State _____ Zip _____

If Student, Name of School/College _____ City _____ State _____

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Person to Contact in Case of Emergency _____ Phone _____

Would you prefer ☐ e-mail or ☐ text when notifying you of upcoming appointment?

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Employer _____ Work Phone _____ SSN# _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Ins. ID # _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Ins. Co. Phone # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Ins. Co. Phone # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

Pharmacy Name_____ Pharmacy Phone_____

	Yes	No
1. Are you in good health at this time?	☐	☐
2. Are you under medical treatment now? If yes, for what condition or treatment _____	☐	☐
3. Have you been hospitalized in the last 5 years? If yes, please explain_____ _____	☐	☐
4. Are you taking any medication(s) including non-prescription, nutritional supplements and vitamins? If yes, please list: _____ _____	☐	☐
5. Do you use tobacco?	☐	☐
6. When were you last treated by a physician?_____ For what condition? _____ _____	☐	☐

8. Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Codeine	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐

9. Women Only:	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

10. Are you currently taking or have taken in the past Biophosphate medications such as Fosomax, Zometa or Aredia?	Yes	No
	☐	☐

7. Do you have or have you had any of the following?

	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting/Seizures	☐	☐
Asthma, Shortness of breath	☐	☐
Low Blood Pressure	☐	☐
Epilepsy/Convulsions, Seizures	☐	☐
Leukemia	☐	☐
Diabetes, Dry Mouth, Excessive Urination	☐	☐
Kidney Diseases, Frequent Urination	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐

	Yes	No
Emotional Problems (Mental Disease)	☐	☐
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia, Thin or Low Blood Count	☐	☐
Emphysema	☐	☐
Cancer or Radiation Treatment	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles/Ulcers	☐	☐
Blood Transfusion	☐	☐

	Yes	No
Excessive Bleeding, Hemophilia	☐	☐
Duodenal or Stomach Ulcer	☐	☐
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke, or Numbness	☐	☐
Hay Fever/Allergies	☐	☐
Tuberculosis, or lived w/ TB Patient	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble, Chest Pain	☐	☐
Respiratory Problems	☐	☐

Name any disorders that you ever had that are not mentioned above?

_____

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam_____

Telephone #_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Have you ever been treated for gum disease?	☐	☐
3. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
4. Are your teeth sensitive to sweet, or sour liquids/foods?	☐	☐
5. Do you feel pain in any of your teeth?	☐	☐
6. Do you have any sores or lumps in or near your mouth?	☐	☐
7. Have you had any head, neck or jaw injuries?	☐	☐
8. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
9. Do you have a bad taste in your mouth?	☐	☐

	Yes	No
10. Do you have frequent headaches?	☐	☐
11. Do you clench or grind your teeth?	☐	☐
12. Do you bite your lips or cheeks frequently?	☐	☐
13. Have you ever had any difficult extractions in the past?	☐	☐
14. Have you ever had prolonged bleeding following extractions?	☐	☐
15. Have you had orthodontic treatment?	☐	☐
16. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
17. Do you like your smile?	☐	☐
18. Do you have any loose teeth?	☐	☐
19. Have any of your teeth shifted?	☐	☐
20. Do you have any dental implants?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

Signature of patient (or parent if minor)

Signature of Doctor _____

PRINTED BY: BEEHIVE PRESS, INC. • 718-654-1200 5-15-17