98 East Main Street
Babylon, New York 11702

Laser Periodontics and Implants
DAVID R. SCHARF, D.M.D.
Periodontal Aesthetics & Advanced Regeneration

Phone (631) 661-6633
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PATIENT REGISTRATION

Name_____

D.O.B. ____/____/___ Age _____

Social Security # _____

Home Address _____

City_____ State _____ Zip_____

Years at Address _____ Rent or Own _____

Email Address _____

Home Phone _____

Business Phone _____

Cell _____

Which telephone would be best for messages? _____

Occupation_____

Employer Name _____

Years at Employer_____

Marital Status (circle one) S M W D

Spouse's Name _____

Emergency Phone Number and contact person

_____

Whom may we thank for referring you to our practice?

_____

Dentist's Name _____

Address _____

Phone _____ Date of last exam _____

Physician's Name _____

Address _____

Phone _____ Date of last exam _____

Findings? _____

What is your present problem and what would you like to have handled today?

_____

DENTAL INSURANCE

So that we may assist you in submitting dental insurance claims, please complete ALL of the following information:

Primary Holder_____

D.O.B. ____/____/___ Social Security # _____

Employer _____

Name_____

Address_____

City_____ State _____ Zip_____

Insurance Carrier_____Group #_____

Insurance Co. Address _____

Phone_____

Secondary Holder_____

D.O.B. ____/____/___ Social Security # _____

Employer _____

Name_____

Address_____

City_____ State _____ Zip_____

Insurance Carrier_____Group #_____

Insurance Co. Address _____

Phone_____

PLEASE COMPLETE OTHER SIDE

MEDICAL HISTORY

These questions all have relevance to your oral health. They will help and protect you. Please complete each item.

1. Have you been hospitalized in the past? ○ Yes ○ No
   Why?_____
2. Have you been under the care of a medical doctor in the past 5 years? ○ Yes ○ No
   Why?_____
3. Have you been sick in past 3, 6, 9, 12 months? ○ Yes ○ No
4. Have you taken any medicine or drugs in the past 2 years? ○ Yes ○ No
   What?_____
5. Do you take aspirin daily or any nutritional supplements or vitamins? ○ Yes ○ No
   What?_____
6. Are you allergic to, or made sick by any medication or drug? ○ Yes ○ No
   What?_____
7. Have you ever had excessive bleeding requiring special treatment? ○ Yes ○ No
8. Have you ever been told to take antibiotics before dental care? ○ Yes ○ No
9. Do you have chest pain, shortness of breath or loss of strength walking upstairs? ○ Yes ○ No
10. Do your ankles swell during the day? ○ Yes ○ No
11. Have you lost or gained more than 10 pounds in the past year? ○ Yes ○ No
12. Are you on a special diet? ○ Yes ○ No
13. Do you have any disease or problem not listed? ○ Yes ○ No
14. Women: Are you or might be pregnant now or anticipate becoming pregnant? ○ Yes ○ No
    Are you taking birth control pills or any hormone medication? ○ Yes ○ No
15. Have you had recent life events that have resulted in stress or tension? ○ Yes ○ No
16. Do you smoke? ○ Yes ○ No
    If yes, how much _____
17. Do you exercise regularly? ○ Yes ○ No
18. Have you ever taken Fosamax (Alendronate), Actonel (Risedronate), Boniva (Ibandronate), Aredia (Pamidronate), Zometa (Zoledronate), Skelid (Tiludronate), Etidrnate (Didronel), Fen-phen? ○ Yes ○ No
    If yes, when did you start the medication? _____
19. Have you ever had breast cancer, prostate cancer or multiple myeloma and been treated for the spread of these cancers to the bone or have you ever had Paget's disease? ○ Yes ○ No
20. Have you travelled to: Liberia, Sierra Leone or Guinea in the last 21 days? ○ Yes ○ No
    If yes, date entered USA _____
    Are you feeling feverish? ○ Yes ○ No

Please check any of the following which you have had or do have

☐ Heart Failure	☐ Artificial Joints	☐ Hay Fever	☐ Glaucoma	☐ Hemophilia
☐ Heart Disease or Attack	☐ Anemia	☐ Sinus Trouble	☐ Cortisone Medication	☐ Venereal Disease
☐ Angina Pectoris	☐ Stroke	☐ Allergies or Hives	☐ Bruise Easily	(Syphilis, Gonorrhea)
☐ High Blood Pressure	☐ Kidney Trouble	☐ Diabetes (also in the family)	☐ Alcoholism	☐ Cold Sores
☐ Heart Murmur	☐ Ulcers	☐ Thyroid disease	☐ HIV	☐ Herpes
☐ Rheumatic Fever	☐ Pain in Jaw Joints	☐ X-ray or Cobalt	☐ Hepatitis A	☐ Epilepsy or Seizure
☐ Congenital Heart Lesion	☐ Mitral Valve Prolapse	Therapy	☐ Hepatitis B (Serum)	☐ Fainting/Dizzy Spells
☐ Scarlet Fever	☐ Emphysema	☐ Chemotherapy	☐ Liver Disease	☐ Psychiatric Treatment
☐ Artificial Heart Valve	☐ Cough	☐ Cancer, Leukemia	☐ Yellow Jaundice	☐ Nervousness
☐ Heart Pacemaker	☐ Tuberculosis (TB)	☐ Arthritis	☐ Blood Transfusion	☐ Sickle Cell Disease
☐ Heart Surgery	☐ Asthma	☐ Rheumatism	☐ Drug Addiction	☐ Canker Sores

Comments_____

_____

_____

1. To the best of my knowledge, all of the answers I have given on this form are true and correct. If I ever have a change in my health, or if my medications change, I will inform Dr. Scharf at my next visit.
2. I authorize Dr. Scharf or designated staff to take models, x-rays, photographs or any other diagnostic materials deemed appropriate by Dr. Scharf to diagnose and document my oral condition. I understand that Dr. Scharf lectures nationally and internationally and is actively involved in publication. I consent to the use of the materials for teaching or publication purposes and understand that my identity will be protected.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.
4. Upon such diagnosis, I authorize Dr. Scharf to perform all recommened treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care. I understand that where appropriate, credit bureau reports may be obtained.

Date_____ Signature _____

Reviewed by _____ Date _____

Print Form