WELCOME NEW PATIENT

Michael B. Seligson, D.D.S.

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. (Please Print Clearly)

We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Patient's Last Name:	First:			Middle:	Preferred:
SSN:	Birth Date: / /	Age:	Sex: ❑ M ❑ F	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Other	
Street Address:					Home Phone: - -
City:	State:		Zip:		Cell Phone: - -
Email Address:			Whom may we thank for referring you?		
Employer:			Occupation		Business Phone: - -
Emergency Contact:			Home Phone: - -		Cell Phone: - -

DENTAL INSURANCE

Please Provide Insurance Card to Reception Desk

Person Responsible for Account: Last		First:		Middle:
SSN:	Birth Date: / /	Age:	Home Phone: - -	Relationship to Patient:
Street Address: (If Different)				Home Phone: - -
City:	State:	Zip:		Cell Phone: - -
Employer:		Occupation		Business Phone: - -
Name of Insurance Company:		Group #:		Subscriber ID:
Mailing Address:	City/State/Zip:			Business Phone: - -
Name of Secondary Insurance Company:	Group #:			Subscriber ID:
Mailing Address:	City/State/Zip:			Business Phone: - -

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT, UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

DENTAL HISTORY

Reason For Appointment:	Are you experiencing any discomfort?:

Former Dentist:	Email Address:	Phone: - -

Last Dental Appt: / /	Last X-Rays: / /	How often do you brush?:	How often do you floss?

Check (✓) Yes or No if you have had any of the following:

❑ Y ❑ N Bad Breath	❑ Y ❑ N Food Collection Between Teeth	❑ Y ❑ N Periodontal Treatment
❑ Y ❑ N Sensitivity to Sweets	❑ Y ❑ N Grinding/Clenching Teeth	❑ Y ❑ N Bleeding Gums
❑ Y ❑ N Sensitivity to Cold	❑ Y ❑ N Loose Teeth or Broken Fillings	❑ Y ❑ N Clicking/Popping Jaw
❑ Y ❑ N Sensitivity to Hot	❑ Y ❑ N Sensitivity when Biting	❑ Y ❑ N Sore/Growths in Mouth

Have you ever had an adverse reaction during / in conjunction with a medical or dental procedure? ❑ Y ❑ N

How do you feel about the appearance of your teeth?:	Other information about dental health / previous treatment:

MEDICAL HISTORY

Physicians Name:	Phone: - -	Date of Last Visit: / /

Have you had any serious illness or operations? ❑ Y ❑ N (If yes, describe)	Are you currently under physician care? ❑ Y ❑ N (If yes, describe)
Have you ever had a blood transfusion? ❑ Y ❑ N (If yes, list approximate dates)	Have you taken a bisphosphonate medication? ❑ Y ❑ N (Brand names include: Fasomax, Actonel, Atelvia, Didronel, & Boniva)

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking Birth Control Pills? ❑ Y ❑ N

Check (✓) Yes or No if you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive	❑ Y ❑ N Cough up Blood	❑ Y ❑ N Kidney Problems	❑ Y ❑ N Spina Bifida
❑ Y ❑ N Anaphylaxis	❑ Y ❑ N Diabetes	❑ Y ❑ N Liver Disease	❑ Y ❑ N Stroke
❑ Y ❑ N Anemia	❑ Y ❑ N Epilepsy	❑ Y ❑ N Mitral Valve Prolapse	❑ Y ❑ N Surgical Implant
❑ Y ❑ N Arthritis/Rheumatism	❑ Y ❑ N Fainting	❑ Y ❑ N Nervous Problems	❑ Y ❑ N Swelling of Feet/ Ankles
❑ Y ❑ N Artificial Heart Valves	❑ Y ❑ N Food/Material Allergy	❑ Y ❑ N Pacemaker/Heart Surgery	❑ Y ❑ N Thyroid Problems
❑ Y ❑ N Artificial Joints	❑ Y ❑ N Glaucoma	❑ Y ❑ N Psychiatric Care	❑ Y ❑ N Tobacco Habit
❑ Y ❑ N Asthma	❑ Y ❑ N Headaches	❑ Y ❑ N Rapid Weight Loss/Gain	❑ Y ❑ N Tonsillitis
❑ Y ❑ N Atopic/Allergy Prone	❑ Y ❑ N Heart Murmur	❑ Y ❑ N Radiation Treatment	❑ Y ❑ N Tuberculosis
❑ Y ❑ N Back Problems	❑ Y ❑ N Heart Problems	❑ Y ❑ N Respiratory Disease	❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Blood Disease	Describe: _____	❑ Y ❑ N Rheumatic/ Scarlet Fever	❑ Y ❑ N Venereal Disease
❑ Y ❑ N Cancer	❑ Y ❑ N Hemophilia/ Abnormal Bleeding	❑ Y ❑ N Shingles	❑ Y ❑ N Other: _____
❑ Y ❑ N Chemical Dependency	❑ Y ❑ N Herpes	❑ Y ❑ N Shortness of Breath	_____
❑ Y ❑ N Chemotherapy	❑ Y ❑ N Hepatitis	❑ Y ❑ N Skin Rash	_____
❑ Y ❑ N Circulatory Problems	❑ Y ❑ N High Blood Pressure		
❑ Y ❑ N Cortisone Treatments	❑ Y ❑ N Jaw Pain		
❑ Y ❑ N Cough, Persistent			

Are you currently taking Medications?: (If Yes, list all)	Do you have allergies to drugs/materials/other?: (If Yes, list all)
_____	_____
_____	_____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change to my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

SIGNATURE: _____ **DATE:** _____

Michael B. Seligson, D.D.S. P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have received a copy of this office's Notice of Privacy Practices.

(You may refuse to sign this acknowledgement)

_____ _____

Patient Signature (Parent /Guardian if under 18 years of age) Date

Personal Health Information Release Form (HIPAA)

Name: _____

Date of Birth _____/_____/_____

Best phone number to reach me at: _____

I authorize your office to leave a message: (circle one) yes no

[ ] I authorize the release of any and all information including the diagnosis, financial and dental records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse: _____

[ ] Child(ren): _____

[ ] Parent: _____

[ ] Other: _____

[ ] I do not authorize the release of my information.

This release of information will remain in effect until terminated by the patient in writing.

_____ _____

Patient Signature (Parent /Guardian if under 18 years of age) Date