Shin Huh, D.M.D P.C
Jeffrey Markowitz, D.D.S.

General and Cosmetic Dentistry

1129 Northern Blvd, Suite 401
Manhasset, New York 11030
office@smilesavers.com
Telephone : (516)-365-3535

Patient Information

Full Name : _____ Preferred Name : _____

Date of Birth : _____ Social Security # : _____

Please check the following that apply: Male ☐ Female ☐ Other ☐ Married ☐ Single ☐ Minor ☐

Home Address : _____ City : _____ State : _____ Zip : _____

Home Phone # : _____ Cell # : _____ Work # : _____

E-mail address : _____ Preferred Method of Contact : _____

Employer : _____

Emergency Contact Name : _____ Phone # : _____

How did you hear of us ? _____ Other family members seen by us :_____

If referred by someone, whom may we thank for the referral ?_____

(If Patient is a minor) Guardian Name : _____ Date of Birth: _____

Relationship to patient : _____ Social Security # _____

Address : _____ City : _____ State : _____ Zip : _____

Home Phone # : _____ Work # : _____ Cell # : _____

Dental Insurance Information (Primary)

Policyholder's Name : _____ Birth Date : _____ Social Security # : _____

Insurance Company : _____ Group # : _____

Employer: _____ Policyholder's I.D # : _____

Patient Relationship to Policyholder : Self ☐ Spouse ☐ Child ☐ Other ☐

Dental History

Do you like your smile? *Yes* or *No* Are you currently in pain? *Yes* or *No* Do your gums bleed? *Yes* or *No*

Reason for visit: _____ How many times a day do you brush? _____

Do you smoke or use chewing tobacco? *Yes* or *No* If yes, how long? _____ How often? _____

What, if anything, would you change about your smile? _____

Do you now have or have you ever experienced pain / discomfort in your jaw (TMJ)? *Yes* or *No*

Have you ever had problems with previous dental treatment? *Yes* or *No*

If yes, please explain: _____

Previous Dentist or Dental Office : _____ Phone # :_____

When was your last dental visit? _____ Do you have any recent x-rays? : _____

Pharmacy Information

Name : _____ Phone Number : _____

Address : _____ City : _____ State : _____ Zip : _____

Additional Medical Information

Physician's Name : _____ Phone # : _____

Have you ever had a serious head, neck, or back injury?_____

Women

Are you or could you be pregnant? ***Yes*** or ***No***

Are you nursing? ***Yes*** or ***No***

Taking Oral Contraceptives? ***Yes*** or ***No***

Are you currently being treated or have ever been treated for any of the following? (check box)

- ☐ Rheumatic Fever
- ☐ Epilepsy / Seizures
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Drug / Alcohol Abuse
- ☐ *High* Blood Pressure
- ☐ *Low* Blood Pressure
- ☐ Diabetes
- ☐ Artificial Valve / Joint
- ☐ Asthma
- ☐ Thyroid Problems
- ☐ HIV / AIDS
- ☐ Mitral Valve Prolapse
- ☐ Heart Surgery
- ☐ Sinus Problems
- ☐ Blood Transfusion
- ☐ Heart Attack
- ☐ Arthritis
- ☐ Autism
- ☐ Cancer (Please specify)
  _____
- ☐ Any Implant / Transplant
- ☐ Heart Murmur
- ☐ Psychiatric Care
- ☐ Pacemaker
- ☐ Excessive Bleeding
- ☐ Bruise Easily
- ☐ Kidney Problems
- ☐ Severe Headaches
- ☐ Stroke
- ☐ Glaucoma
- ☐ **NONE**

Please list ***any medical condition*** not listed above :

_____

Allergies

Are you allergic to any of the following? (Check box)

- ☐ Latex
- ☐ Penicillin
- ☐ Aspirin
- ☐ Erythromycin
- ☐ Codeine
- ☐ Tetracycline
- ☐ Ibuprofen
- ☐ Tylenol
- ☐ Sulfa
- ☐ Dental Anesthetic
- ☐ Other : _____
- ☐ **NONE**

Medications

Do you Premedicate? *Yes* or *No* - If YES, with what _____

Please list ***all medications*** you are currently taking (or if you have a list please provide us a copy) :

_____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status.

Patient Signature : _____ Date : _____

Parent/Guardian Signature, if patient is a minor : _____ Date : _____