Columbia University Dental Associates

- ORAL & MAXILLOFACIAL SURGERY ASSOCIATES
- ORAL PATHOLOGY

212-305-4599

The Faculty Practice of Columbia University College of Dental Medicine

Date: _____

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

In Case of Emergency Contact

Name: _____ Relationship: _____

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

Whom can we thank for referring you to us? _____

Account Information

☐ Person responsible for this account is the same as above

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

Insurance Company: _____ ID Number: _____ Group Number: _____

☐ Additional Insurance

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

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

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

Insurance Company: _____ ID Number: _____ Group Number: _____

Agreement & Consent

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient.

I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits.

Patient or Responsible Party Signature: **X** _____ Date: _____

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Medical History

Although our Dental Team primarily treats areas in and around your mouth, the health of your entire body can influence treatment you may receive. Certain health conditions or medication can have significant interactions with the dentistry you may receive. Please answer the following questions as accurately as possible. Thank You!

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain: _____
Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____
Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____
Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____
Please list any medications, pills, or drugs you are taking: _____

_____

Women: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS / HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Renal Dialysis	☐ Other Serious Illness
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A, B, or C	☐ Rheumatic Fever	Please Explain:_____
☐ Anaphylaxis	☐ Drug Addiction	☐ Headaches	☐ Rheumatism	_____
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Scarlet Fever	_____
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Shingles	_____
☐ Arthritis / Gout	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sickle Cell Disease	_____
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble	_____
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida	_____
☐ Asthma	☐ Fainting Spells / Dizziness	☐ Kidney Problems	☐ Stomach Disease	_____
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Intestinal Disease	_____
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Stroke	_____
☐ Breathing Problems	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Swelling of Limbs	_____
☐ Bruise Easily	☐ Genital Herpes	☐ Lung Disease	☐ Thyroid Disease	_____
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Problems	☐ Tonsillitis	_____
☐ Chemotherapy	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Tuberculosis	_____
☐ Chest Pains	☐ Heart Attack / Failure	☐ Parathyroid Disease	☐ Tumors or Growths	_____
☐ Cold Sores / Fever Blisters	☐ Heart Murmur	☐ Psychiatric Care	☐ Ulcers	_____
☐ Congenital Heart Disease	☐ Heart Pace Maker	☐ Radiation Treatments	☐ Venereal Disease	_____
☐ Convulsions	☐ Heart Trouble / Disease	☐ Recent Weight Loss	☐ Yellow Jaundice	_____

Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my patient's) health. I will not hold my Dentist or any members of his / her Dental Team responsible for errors or emissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: **X** _____ Date: _____