



DAVID L. LERNER D.D.S., P.C.
THE CENTER for HOLISTIC DENTISTRY
 2649 Strang Boulevard, Yorktown Heights, NY 10598
 (914)-245-4041

Patient Name: _____ Date: _____

Last First MI

Male Female Mr. Mrs. Ms. Dr. Miss Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone#: _____

Address: _____
 Street Apartment #

City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Heavy Metal Toxicity | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke | <input type="checkbox"/> Pain in Ears or Face |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sores in Your Mouth or Lips |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tumors | <input type="checkbox"/> Clicking or Grinding Noises |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Ringing, Buzzing, or Clogged Ears |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Chronic Back Pain or Stiffness |
| <input type="checkbox"/> Chemical Sensitivity | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Teeth Sensitive to Hot or Cold |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Problems Chewing or Talking |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral Valve Prolapse | OTHER: _____ | <input type="checkbox"/> Limited Movement of Your Head, Neck, or Arms |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nervous Disorders | _____ | <input type="checkbox"/> Grinding or Clenching of Teeth |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pre-medicate | <input type="checkbox"/> Bad Breath |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pregnancy | | <input type="checkbox"/> Poor Posture |
| | Due date: _____ | | <input type="checkbox"/> Loose Teeth |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Birth Control | <input type="checkbox"/> Swollen or Bleeding Gums | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever | | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Rheumatism | | |
| <input type="checkbox"/> Head Injuries | | | |

Have you ever had any complications following dental treatment? Yes No
 If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
 If yes, please explain: _____

Are you now under the care of a physician? Yes No
 If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? Yes No
 If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

 Signature of patient, parent or guardian Date: _____

Please continue to next page

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental/Medical Office Yellow Pages NY Naturally Internet Holistic Directory
 Chronogram Pennysaver Newsletter Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Please continue to next page

Please circle the appropriate answer:

- 1) My mouth is
 - a) very comfortable
 - b) moderately comfortable
 - c) uncomfortable

- 2) I/ I am
 - a) think the appearance of my mouth is excellent
 - b) satisfied with the appearance of my mouth
 - c) dissatisfied with the appearance of my mouth

- 3) I
 - a) will do anything to keep my natural teeth
 - b) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them
 - c) don't care whether I keep them or not

- 4) I
 - a) have set goals for my oral health
 - b) want to set goals concerning my dental care
 - c) never set goals concerning my oral health

- 5) I have / I
 - a) always done the best that was recommended for my dental health
 - b) have not done what dentists have recommended for my mouth
 - c) rarely go, and don't care much about having any dental work

- 6) I have
 - a) put dentistry for myself and my family high on my priority list
 - b) put dentistry for myself and my family low on my priority list
 - c) it's on my list but hard to find

- 7) I think my present state of Dental Health is:
 - a) excellent
 - b) good
 - c) poor

- 8) I aspire to a mouth with:
 - a) excellent health
 - b) good health
 - c) poor health

Have you ever had periodontal treatment ? Y N
 Have you had orthodontic treatment ? Y N

Do you have any other dental conditions you wish us to know about?

If you could wave a magic wand and change anything about the condition or appearance of your teeth what would you want to change ?

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Payments are due at time of service, unless other arrangements were made prior to treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of **three months** from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within 48 hours of appointed time for treatment. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I agree to give this office at least **48 hour notice of cancellation** for an appointment scheduled. If not ,a fee of **\$ 60.00 per ½ hour** can be billed to you.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
 Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
 Signature of guarantor of payment/responsible party