Michelle Bailey, DDS
Periodontist

Michelle Bailey DDS Periodontist

SHORE ROAD DENTAL
8701 Shore Road Suite A Corner of 87th Street and Shore Road
Brooklyn, NY 11209 Tel: (718) 836-9000
www.bayridgeperiodontist.com

PATIENT HEALTH HISTORY

Name: First, Middle, Last | Sex | Birth Date | Marital Status

Address (Street, City, State) | Apt# | Zip Code | Social Security Number

Cell Phone | Work Phone | Business Name and Address

Home Phone | Email

General Dentist's Name | Referred to this office by | Occupation

In case of emergency, who should we contact? | Relation | Phone

DENTAL INSURANCE INFORMATION

Primary Insurance Company

Name & Address | **Subscriber Social Security Number & Birth Date**

Subscriber's Name and ID# | Group or Company Name

Group Number | Patient Relationship to Subscriber (self, spouse, child, etc.)

Secondary Insurance Company

Name & Address | **Subscriber Social Security Number & Birth Date**

Subscriber's Name and ID# | Group or Company Name

Group Number | Patient Relationship to Subscriber (self, spouse, child, etc.)

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MEDICAL HISTORY

Medical Doctor's Name _____ Address _____ Phone _____

Date of My Last Physical Examination _____ Results _____

Are you being treated by a medical doctor now? If yes, for what reason?

_____

Are you taking any medication at the present time? If yes, what?

_____

Are you sensitive or allergic to any medicine? If yes, what?

_____

Have you ever been hospitalized or had any surgical operations? If yes, list reasons and dates.

_____

Have you ever had any blood transfusions? If yes, give reason.

Please check all that apply:

- Yes · No HIV Positive
- Yes · No Gall Bladder Disease
- Yes · No Low Blood Pressure
- Yes · No Asthma
- Yes · No Nervousness
- Yes · No Anemia
- Yes · No Tuberculosis
- Yes · No Fainting or Dizzy Spells
- Yes · No Ulcers (Stomach or Intestinal)
- Yes · No Scarlet Fever
- Yes · No Thyroid Disease (or Goiter)
- Yes · No Venereal Disease (Syphilis or Gonorrhea)
- Yes · No Psychiatric Treatment
- Yes · No Kidney Disease
- Yes · No Hepatitis
- Yes · No Bladder Disease
- Yes · No High Blood Pressure
- Yes · No AIDS
- Yes · No Diabetes (Sugar Disease)
- Yes · No Stroke
- Yes · No Hay Fever
- Yes · No Epilepsy or Seizures
- Yes · No Allergies or Hives
- Yes · No Rheumatic Fever
- Yes · No Pacemaker
- Yes · No Arthritis
- Yes · No Heart Murmur
- Yes · No X-Ray or Cobalt Treatment
- Yes · No Heart Disease
- Yes · No Angina Pectoris
- Yes · No Chemotherapy (Cancer, Leukemia)
- Yes · No Osteoporosis or Osteopenia
- Yes · No Pneumonia

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- Yes · No COPD
- Yes · No Cognitive Impairment
- Yes · No Obesity
- Yes · No Metabolic Syndrome
- Yes · No Do you have pain in the chest upon exertion?
- Yes · No Do you have shortness of breath after mild exercise?
- Yes · No Do you use extra pillows to sleep?
- Yes · No Do your ankles swell?
- Yes · No Do you bruise easily?
- Yes · No Have you ever had yellow jaundice?
- Yes · No Do you have to urinate (pass water) more than 6 times a day?
- Yes · No Are you thirsty much of the time?
- Yes · No Does your mouth frequently become dry?
- Yes · No Have you lost or gained weight (more than 10 lbs.) in the past year?
- Yes · No Are you following a diet?
- Yes · No Do you have cataracts or glaucoma?
- Yes · No Do you have difficulty swallowing?
- Yes · No Has a doctor ever said you have cancer or a tumor?
- Yes · No Have you ever had excessive bleeding from a cut or wound?
- Yes · No Do you have frequent severe headaches?
- Yes · No Do you worry a great deal?
- Yes · No Are you under abnormal stress? (e.g., marital, business, or social)
- Yes · No Do you feel you need psychiatric care or advice?
- Yes · No Do you sometimes take medicine to relieve anxiety?

Do you have any disease, condition, or problem not listed above?

If yes, explain: _____

Females

- Yes · No Do you have trouble with your periods? (if you do not menstruate, answer no)
- Yes · No Did you have any complications during pregnancy (if you have never been pregnant, answer no)
- Yes · No Are you pregnant? (date of delivery _____) .
- Yes · No

Are you taking oral contraceptives (birth control pills)?

Dental History

- Yes · No Have you had any serious trouble associated with any previous dental treatment?

If yes, explain: _____

- Yes · No Do you bleed excessively after tooth extraction?
- Yes · No Have you recently had dental x-rays? If yes, when: _____
- Yes · No Have you had undesirable reactions to local or general anesthetics (e.g., Novocain or gas)?
- Yes · No Do you clench or grind your teeth?
- Yes · No Are any of your teeth sensitive to cold or sweets?
- Yes · No Are you dissatisfied with the appearance of your teeth?
- Yes · No Have you had excessive swelling or pain after oral surgery?
- Yes · No Have your teeth been cleaned recently?
- Yes · No Do you have bleeding gums?

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- Yes · No Do you have a bad taste in your mouth?
- Yes · No Does food pack between your teeth?
- Yes · No Does your jaw click or pop when you chew?
- Yes · No Have you ever received treatment for periodontal disease?
- Yes · No Has a dentist ever ground your teeth to correct your bite?
- Yes · No Are you willing to become actively involved in the treatment of your periodontal disease?

Briefly state your feelings toward dentures: _____

_____

What is your chief complaint concerning your mouth or teeth? _____

_____

To the best of my knowledge, all of the above answers are true and correct. If I have any change in my health, I will inform Dr. _____ at my next appointment.

_____ _____
Signature of Patient Date

Financial Liability Agreement

Date: ____ / ____ / ____

Name: _____

DOB: ____ / ____ / ____

To Whom It May Concern:

I, _____ , understand if my insurance policy, plan or agency does not pay for services that's not covered under my plan, I will be financially liable for such services. Any claims denied or unpaid for any reason will be billed directly to me and I am ultimately responsible for any and all non-covered services.

Services Rendered:

_____ _____
Signature: Date:

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PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address:

Street: _____

City: _____ State: _____ ZipCode:_____

Pharmacy Telephone # : _____

Patient Full Name: _____

Allergic to any medications? Yes No

If "Yes", provide the names of the medications you are allergic to:

_____

Note: **We send prescriptions electronically to the pharmacy mentioned above**