Port Jefferson Dental
488 Terryville Road
Port Jefferson NY 11776
631-473-5300

Hamid Jarbarry DDS

Patient Registration

Today's Date_____

Name_____Preferred Name_____

Address_____

City_____State_____Zip_____

Telephone Home_____Cell_____Work_____Ext__

Birth Date_____Social Security #_____Email_____

Sex: Male____Female_____ Martial Status: Single__Married__Separated__Divorced__Widowed____

How did you hear about our practice?_____

_____

To get to know you better, please list any hobbies, interests, or sports

_____

If a child or student, give school name and grade level_____

Purpose of visit_____

Employer's Name_____

Employer's Address_____

City_____State_____Zip_____

Present position_____How long held?_____

_____

Who will be responsible for this account? Self____Spouse__Parent_____

Person responsible for this account, other than above patient:

Name:_____Birth Date_____

Address_____

City_____State_____Zip_____

Home phone_____Work phone_____Ext_____

Employer's Name_____

Employer's Address_____City_____State_____Zip____

Social Security #_____

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For Patients covered by Dental Insurance:

Subscriber's Name_____Date of Birth_____

Employer's Name_____

Employer's Address_____

City_____State_____Zip_____

Social Security Number_____Insurance ID_____

Insurance Company_____

Address_____City_____State_____Zip_____

Relationship to Patient: Self___Spouse___Parent or Guardian_____

Is the patient covered by another dental insurance?_____

Is yes, please fill out the next section.

Secondary Dental Insurance

Subscriber's Name_____Date of Birth_____

Employer's Name_____

Employer's address_____

City_____State_____Zip_____

Social Security Number_____Insurance ID_____

Insurance Company_____

Address_____City_____State____Zip_____

Relationship to Patient: Self___Spouse___Parent or Guardian_____

Appointments: This time is reserved exlusively for you. 24 hours notice is appreciated if you are unable to keep your appointment. A minimum charge will be made for a broken or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of office overhead which still has to be paid whether you are present or not. In addition, other patients cannot be scheduled because WE HAVE RESERVED THE TIME FOR YOU!

Payments are due at time of service.
A late fee of 1.5% will be applied
to accounts over 60 days past due.
In addition, 35% of the outstanding balance
plus attorney fees will be applied to
accounts transferred to collection.

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HEALTH HISTORY

Patient's Name_____**Phone**_____**Date**_____

Place a mark on yes or no to indicate if you have had any of the following:
Have you been advised by your physician that you need to be pre-medicated for dental treatment?Yes☐No☐

Anemia	☐Yes☐No	Eye Disease	☐Yes☐No	Respiratory Disease	☐Yes☐No
Arthritis,	☐Yes☐No	Fainting or Dizziness	☐Yes☐No	Rheumatic Fever	☐Yes☐No
Asthma	☐Yes☐No	Frequent ear infections	☐Yes☐No	Scarlet Fever	☐Yes☐No
Bleeding abnormally After extractions	☐Yes☐No	Headaches	☐Yes☐No	Shortness of Breath	☐Yes☐No
Blood Disease	☐Yes☐No	Heart Murmer	☐Yes☐No	Sinus Trouble	☐Yes☐No
BloodThinners	☐Yes☐No	Heart Problems	☐Yes☐No	Stents	☐Yes☐No
Blood Trasfusion	☐Yes☐No	Hepatitis Type____	☐Yes☐No	Stroke	☐Yes☐No
Cancer	☐Yes☐No	Herpes	☐Yes☐No	Swollen Neck Glands	☐Yes☐No
Chemical Dependency	☐Yes☐No	High Blood Pressure	☐Yes☐No	Thyroid Problems	☐Yes☐No
Chemotherapy	☐Yes☐No	HIV positive/AIDS	☐Yes☐No	Tuberculosis/TB	☐Yes☐No
Circulatory Problems	☐Yes☐No	Jaundice	☐Yes☐No	Tumor or Growths	☐Yes☐No
Congenital Heart Lesions	☐Yes☐No	Jaw pain	☐Yes☐No	Ulcer or Colitis	☐Yes☐No
Cortisone Treatments	☐Yes☐No	Joint Replacement(knee,hip etc.)	☐Yes☐No	Venereal Disease	☐Yes☐No
Cough, Persistant Or Bloody	☐Yes☐No	Kidney Disease	☐Yes☐No		
Depression	☐Yes☐No	Liver Disease	☐Yes☐No	WOMEN:	
Diabetes	☐Yes☐No	Low Blood Pressure	☐Yes☐No	Are you pregnant	☐Yes☐No
Emotional problems	☐Yes☐No	Mitral Valve Prolapse	☐Yes☐No	Due Date_____	
Emphysema	☐Yes☐No	Nervousness	☐Yes☐No	Are you taking Birth control pills	☐Yes☐No
Epilepsy/seizures	☐Yes☐No	Pacemaker	☐Yes☐No		
		Radiation treatment	☐Yes☐No		

Medications: Have you ever taken any of the following bisphosphonate? Fosamax___Boniva___Actonel___Other__

Describe any current medical condition or treatment, even though not listed above._____

Allergies: ☐Aspirin☐Codeine☐Latex☐Penicillin☐Sulfur☐Local anesthesia☐Other_____

To my knowledge, the above answers are correct. If there are any changes, I will let the doctor know.

Date_____**Signature**_____

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Medical and Dental History

Patient's Name_____**Today's Date**_____

Date of Birth_____

Are you having pain and discomfort at this time? Yes☐No☐

Have you ever had a bad dental experience? Yes☐_No☐

When was your last Dental exam? _____

When and where were your last dental x-rays?_____

Do you have or do you use any of the following?
Indicate with a (√).

- ☐Gums that bleed
- ☐Gums that have pulled away from your teeth
- ☐Bad Breath
- ☐Teeth that are sensitive to cold, heat, sweets,& pressure
- ☐Clenching or grinding
- ☐Swelling or lumps in mouth
- ☐Pain around the ear
- ☐Unpleasant Taste
- ☐Periodontal Treatment
- ☐Mouth Breathing
- ☐Cigarettes, pipe or Cigar Smoking
- ☐Dental floss
- ☐Anti-plaque Rinses
- ☐Gums that are red,swollen or tender
- ☐Teeth that are loose
- ☐Change in the way your teeth fit together
- ☐Food impaction
- ☐burning tongue
- ☐Frequent blisters on lips, or mouth(cold sores)
- ☐Unusual sounds in ear when eating
- ☐Complications from extractions
- ☐Orthodontic treatment
- ☐Oral Habits(i.e. Fingernail biting,etc.)
- ☐Frequency of Brushing___times per day
- ☐Inter Dental Stimulators
- ☐Fluoride Supplements

Are you under the care of a physician now?_____

Are you taking any medication now?_____

Have you been a patient in the hospital in the last two years_____

Have you had any major operation?____**If so what?**_____

Physician's Name_____**Date of last exam**_____

Address_____

City_____**State**_____**Zip**_____**Phone**_____

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SIGNATURE RELEASE STATEMENT

1. Process all insurance claims.
2. To ensure payment for services rendered.
3. To release medical information to insurance companies, and
4. To release information to other medical/dental providers, when necessary for treatment.

I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Jabbary. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Please Print

Patient_____Responsible Party_____

Signature_____Date_____Witness_____

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