Shaun Massiah, DMD, PC
50 W. 97th Street, Suite 1C
New York, NY 10025
(212)222-5225

Patient Information

Patient Name: _____ ☐ Male ☐ Female
Last First MI
Social Security #: _____Birth Date:_____ ☐ Married ☐ Single ☐ Child ☐ Other
Phone (Home): _____ (Cell):_____E-mail : _____
Address: _____
Street Apartment #
_____
City State Zip Code

Dental and Medical Health History Information

Date of Last Dental Visit: _____ Reason for this visit:_____

CIRCLE THE APPROPRIATE ANSWER
Are you under a physician's care?_____ YES NO

Name of Physician: _____ Phone No. _____

Are you taking any medications (Rx or Over the Counter)?_____ YES NO

Have you ever had any of the following? Please Check YES or NO:

Y N	Y N	Y N	Y N
☐ ☐AIDS/HIV	☐ ☐Epilepsy	☐ ☐Jaundice	☐ ☐Sinus Problems
☐ ☐Allergies _____ _____	☐ ☐Excessive Bleeding	☐ ☐Kidney Disease	☐ ☐Stomach Problems
☐ ☐Fainting/Dizziness	☐ ☐Fainting	☐ ☐Latex/Metal Allergy	☐ ☐Stroke
☐ ☐Anemia	☐ ☐Glaucoma	☐ ☐Liver Disease	☐ ☐Tuberculosis
☐ ☐Arthritis/ Rheumatism	☐ ☐Growths	☐ ☐Nervous Disorders	☐ ☐Tumors
☐ ☐Artificial Joints	☐ ☐Hay Fever	☐ ☐Pacemaker	☐ ☐Ulcers
☐ ☐Asthma	☐ ☐Head Injuries	☐ ☐Pregnancy Due date:_____	☐ ☐Venereal Disease
☐ ☐Blood Disease	☐ ☐Heart Disease	☐ ☐Birth Control	☐ ☐Codeine Allergy
☐ ☐Cancer	☐ ☐Heart Murmur/MVP	☐ ☐Respiratory Problems	☐ ☐Penicillin Allergy
☐ ☐Diabetes	☐ ☐Hepatitis	☐ ☐Rheumatic Fever	OTHER:
☐ ☐Dizziness	☐ ☐Low Blood Pressure	☐ ☐Radiation Treatment	☐ _____
	☐ ☐High Blood Pressure		☐ _____

- 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:_____
- Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates)for bone tumors, excessive calcium in your blood or osteoporosis? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you taken any prescription drugs fenfluramine, combined with phentrmine (fen-phen), dexfenfluramine (redux), or other weight loss products? ☐ Yes ☐ No
- Do you smoke, chew, use snuff or any other forms of tobacco? ☐ Yes ☐ No
- 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.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

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

☐ Zoc Doc ☐ 1-800-DENTIST ☐ DR. OOGLE ☐ Internet ☐ Dental Office ☐ Other_____

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

Dental Insurance Information

Name of Insured (Subscriber)_____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insurance Carrier Name (as it appears on card): _____

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Medical Insurance Information

Name of Insured (Subscriber)_____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insurance Carrier Name (as it appears on card): _____

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

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.

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 or assist in making collections from insurance companies and will credit any such collections to the patient's account. 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 and the recommended treatment listed on any Treatment Plan may change if I delay treatment.

In consideration for the professional services rendered to me, I agree to pay for any services not covered by insurance at the time said services are rendered, or within five (5) days of billing if credit shall be extended. 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 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