Klodiana Margariti, D.D.S., P.C.
45 East End Ave, Suite 1 N, New York, NY 10028

Welcome to our Practice! Please complete this form as accurately as possible. It is important for us to have this information in order to provide the best possible care for you. Your privacy is important to us. The information you share with us will remain strictly confidential.

PATIENT INFORMATION

Today's Date: _____

First Name: _____ MI: ____ Last Name: _____ Gender: ☐ M ☐ F

Family Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Partnered for ____ years ☐ Minor

Date of Birth:_____ SS#: _____ Name/Emergency #:_____

Home #: _____ Work: _____ Cell: _____ Email: _____

Address: _____ Apt#:_____ City: _____ State: _____ Zip Code: _____

MEDICAL HISTORY

Physician Name:_____ Tel: _____ Date of Last Physical:_____

Please check YES or NO to indicate if patient has, has had, or has been diagnose with any of the following:

Y N	Y N	Y N	Y N
☐☐ Pregnant _____ months	☐☐ Thyroid Problems	☐☐ Cancer/Tumors	☐☐ Glaucoma
☐☐ Heart Surgery/Pacemaker	☐☐ Kidney Problems	☐☐ Shingles	☐☐ Asthma
☐☐ Heart Murmur	☐☐ Liver Problems	☐☐ Hepatitis	☐☐ Artificial Bones/Joints
☐☐ Heart Attack/Stroke	☐☐ Respiratory Problems	☐☐ HIV/AIDS/ARC	☐☐ Arthritis/Rheumatism
☐☐ Mitral Valve Prolapse	☐☐ Sinus Problems	☐☐ Leukemia	☐☐ Severe/Frequent Headache
☐☐ Artificial Valves	☐☐ Stomach Problems/Ulcers	☐☐ Chemotherapy	☐☐ High/Low Blood Pressure
☐☐ Rheumatic Fever	☐☐ Venereal Disease	☐☐ Emphysema	☐☐ Diabetes/Hypoglycemia
☐☐ Congenital Heart Defect	☐☐ Psychiatric Problems	☐☐ Anemia	☐☐ Codeine Allergy
☐☐ Chest Pains	☐☐ Tuberculosis TB	☐☐ Ulcer	☐☐ Penicillin Allergy
☐☐ Nervousness	☐☐ Jaw Problems TMJ/TMD	☐☐ Bleeding Problems	☐☐ Latex Allergy
☐☐ Fainting/Seizures/Epilepsy	☐☐ Alcohol / Drug Abuse	☐☐ Back Problems	☐☐ Other Allergy: _____

Other medical complication not listed above: _____

Are you taking any medications? _____

DENTAL HISTORY

Reason for today's visit:_____ Last Cleaning: _____ Last X-rays:_____

Please indicate check all that applies to patient:

☐ Discomfort, Clicking or Jaw Popping	☐ Lost or Broken Filling(s)	☐ Stained Teeth	☐ Smoke _____ time/day
☐ Red, Bleeding or Swollen Gums	☐ Teeth Grinding	☐ Locking Jaw	☐ Drugs _____ time/day
☐ Sensitive Tooth or Gums	☐ Ringing Ears	☐ Bad Breath	☐ Floss _____ time/day
☐ Blisters/Sores in or Around the Mouth	☐ Broken/Chipped Tooth	☐ Denture	☐ Brush _____ time/day
☐ Pain/how long?_____	☐ Other:_____		

RESPONSIBLE PARTY

☐ self ☐ Spouse ☐ Father ☐ Mother ☐ Other: _____

Name: _____ SS#: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ ID #: _____ Phone: _____

INSURANCE

Primary Dental Insurance: _____

Group Name: _____ Group #:_____

Plan:_____ ID#:_____

Primary Insured:_____

SS#: _____ DOB: _____

Relationship to Primary Insured:_____

Employer: _____

Address:_____

Phone: _____

Secondary Dental Insurance: _____

Group Name: _____ Group #:_____

Plan:_____ ID#:_____

Primary Insured:_____

SS#: _____ DOB: _____

Relationship to Primary Insured:_____

Employer: _____

Address:_____

Phone: _____

Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with our office. If the account is not paid in full of the date of services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges (5% per month) and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I have received a notice of my HIPPA rights and understand that a copy can be obtained at http://www.hhs.gov/ocr/hipaa/finalreg.html. I also understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date:_____

☐ Adult Patient (Self) ☐ Parent or Guardian ☐ Spouse