

TODAY'S
DATE _____

**HENRY and LUCY MOSES DIVISION
and the
JACK D. WEILER DIVISION
OUTPATIENT PRACTICE INFORMATION**

REVISIT
 NEW

PATIENT INFORMATION

PATIENT'S NAME		SOCIAL SECURITY NO.		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
STREET ADDRESS		APT. NO.	DATE OF BIRTH	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> SEP. <input type="checkbox"/> DIV.	
CITY / STATE		ZIP CODE		TELEPHONE NO. ()	
REFERRING PHYSICIAN NAME		STREET ADDRESS		CELL/MOBILE NO. ()	
CITY / STATE		ZIP CODE		TELEPHONE NO. ()	

EMPLOYER INFORMATION

COMPANY NAME	PATIENT'S OCCUPATION
COMPANY STREET ADDRESS	TELEPHONE NO. () EXT.
CITY / STATE	ZIP CODE

PERSON RESPONSIBLE FOR PAYMENT (OTHER THAN PATIENT)

NAME	RELATION TO PATIENT
STREET ADDRESS	APT. NO.
CITY / STATE	ZIP CODE TELEPHONE NO. ()

EMERGENCY CONTACT INFORMATION

NAME	HOME TELEPHONE NO. ()
RELATIONSHIP	BUSINESS TELEPHONE NO. () EXT.

INSURANCE INFORMATION

#1	INSURANCE CARRIER	POLICY NO.	GROUP	PLAN	SUBSCRIBER NAME	DATE OF BIRTH
	INSURANCE CARRIER ADDRESS		CITY / STATE		ZIP CODE	PATIENT RELATION TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> DEP <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTH
#2	INSURANCE CARRIER	POLICY NO.	GROUP	PLAN	SUBSCRIBER NAME	DATE OF BIRTH
	INSURANCE CARRIER ADDRESS		CITY / STATE		ZIP CODE	PATIENT RELATION TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> DEP <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTH
#3	INSURANCE CARRIER	POLICY NO.	GROUP	PLAN	SUBSCRIBER NAME	DATE OF BIRTH
	INSURANCE CARRIER ADDRESS		CITY / STATE		ZIP CODE	PATIENT RELATION TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> DEP <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTH
WORKMAN'S COMPENSATION	EMPLOYER'S INSURANCE CARRIER NAME			CODE NO.	CASE NO.	WCG NO.
	INSURANCE CARRIER ADDRESS					
NO FAULT INSURANCE	INSURANCE CARRIER NAME					FINF NO.
	INSURANCE CARRIER ADDRESS					

Acuso recibo de la Notificación sobre prácticas de privacidad

MR# _____

FOR OF

IDX. ACCT. NO. _____ DATE REGISTERED _____

FIRMA _____

FECHA _____

MMC1530 (05/03)

PATIENT: _____

ACCOUNT NUMBER: _____

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Authorization for release of information by the faculty practice of the Montefiore Medical Center

I hereby authorize and direct the above named faculty practice, having treated me to release to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such services rendered during hospitalization and medical care and to permit representative thereof to examine and make copies of all records relating to such care and treatment. A photostatic copy of this signature may be used as a substitute.

Date	Print name of patient or authorized representative
	Signature of patient or authorized representative

I hereby, assign, transfer, and set over to the below named Medical Group, sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependent by such Medical Group. A photostatic copy of this signature may be used as a substitute.

ASSIGNMENT TO: The faculty practice of the Montefiore Medical Center

Date	Print name of patient or authorized representative
Signature of patient or authorized representative	Relation to patient



QUEST

MONTEFIORE



MONTEFIORE MEDICAL CENTER
The University Hospital
for the Albert Einstein College of Medicine
Henry and Lucy Moses Division
Jack D. Weiler Division

MEDICAL HISTORY QUESTIONNAIRE

ADDRESSOGRAPH

First Name: Last Name: Date:

Date of Birth: Sex: M / F SS No.: Height: Weight:

If you are completing this form for another person, what is your name and relationship?

Chief Dental Complaint:

For the following questions, circle Yes or No, whichever applies. Your answers are for our records only and will be confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

- 1. Are you in good health? Yes No
2. Has there been any change in your general health within the past year? Yes No
3. When was your last physical examination? Physician's Name and Phone Number:
4. Are you currently under the care of a physician? Yes No
5. Have you had any serious illness, operation, or been hospitalized in the past 10 years? Yes No
6. Are you taking any medication(s) including non-prescription medicine? Yes No
7. Do you have or have you had any of the following medical problems?
a. Damaged or artificial heart valves, heart murmur or rheumatic heart disease
b. Cardiovascular disease (heart attack, angina, abnormal heart rate, high blood pressure, arteriosclerosis, stroke)
c. Diabetes
d. Hepatitis, jaundice or liver disease
e. AIDS or HIV infection
f. Respiratory problems - persistent cough, asthma, emphysema, bronchitis, etc.
g. Arthritis or painful swollen joints
h. Epilepsy (seizures) or other neurological disease
i. Mental depression
8. Do you bruise easily or have abnormal bleeding? Yes No
9. Have you ever had any treatment for a tumor or growth? Yes No
10. Are you allergic or have you had a reaction to:
a. Local anesthetics
b. Penicillin or other antibiotics
c. Aspirin
d. Codeine or other narcotics
e. Other:

PLEASE TURN OVER TO COMPLETE THE REVERSE SIDE

Patient Name _____ MR # _____ Acct # _____

11. Do you smoke? Yes No
If yes, how many packs per day? _____ For how many years? _____

12. Have you ever been treated for osteopenia, osteoporosis, multiple myeloma, Paget's disease, breast, lung or prostate cancer Yes No
If so, which one? _____
Are you still being treated for the condition? Yes No

13. Have you ever taken DIDRONEL, SKELID, AREDIA, ZOMETA, FOSAMAX, ACTONEL or BONIVA? Yes No
If so, which one? _____
For how long have you taken this medication? _____
What is the name and phone number of the physician who prescribed the medication?

14. Women:
1. Are you pregnant? Yes No
2. Are you nursing? Yes No
3. Are you taking birth control pills? Yes No

Is there anything else that you think I should know about you? Yes No
If so, please explain: _____

I certify that I have read and understand the above. I acknowledge that my answers, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Date

Signature of Patient