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 ☐ MALE ☐ FEMALE
STREET ADDRESS	APT. NO.	DATE OF BIRTH	MARITAL STATUS ☐ S ☐ M ☐ W ☐ SEP. ☐ 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 ☐ SELF ☐ DEP ☐ SPOUSE ☐ OTH		
#2	INSURANCE CARRIER	POLICY NO.	GROUP	PLAN	SUBSCRIBER NAME	DATE OF BIRTH
	INSURANCE CARRIER ADDRESS	CITY / STATE	ZIP CODE	PATIENT RELATION TO INSURED ☐ SELF ☐ DEP ☐ SPOUSE ☐ OTH		
#3	INSURANCE CARRIER	POLICY NO.	GROUP	PLAN	SUBSCRIBER NAME	DATE OF BIRTH
	INSURANCE CARRIER ADDRESS	CITY / STATE	ZIP CODE	PATIENT RELATION TO INSURED ☐ SELF ☐ DEP ☐ SPOUSE ☐ OTH		

WORKMAN'S COMPENSATION	EMPLOYER'S INSURANCE CARRIER NAME	CODE NO.	CASE NO.	WCG NO.
	INSURANCE CARRIER ADDRESS			DATE OF INJURY
NO FAULT INSURANCE	INSURANCE CARRIER NAME			FINE NO.
	INSURANCE CARRIER ADDRESS			

Acuso recibo de la Notificación sobre prácticas de privacidad

MR# _____

FIRMA _____ FECHA _____

MMC1530 (05/03)

FOR OF

IDX. ACCT. NO.	DATE REGISTERED
GENERAL COMMENTS	

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

   If so, for what conditions? _____
5. Have you had any serious illness, operation, or been hospitalized in the past 10 years? ..... Yes No

   If so, what was the illness or problem? _____
6. Are you taking any medication(s) including non-prescription medicine? ..... Yes No

   If so, what medication(s) are you taking? _____
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 ..... Yes No
   b. Cardiovascular disease (heart attack, angina, abnormal heart rate, high blood pressure, arteriosclerosis, stroke) ..... Yes No
   c. Diabetes ..... Yes No
   d. Hepatitis, jaundice or liver disease ..... Yes No
   e. AIDS or HIV infection ..... Yes No
   f. Respiratory problems - persistent cough, asthma, emphysema, bronchitis, etc. ..... Yes No
   g. Arthritis or painful swollen joints ..... Yes No
   h. Epilepsy (seizures) or other neurological disease ..... Yes No
   i. Mental depression ..... Yes No
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 ..... Yes No
    b. Penicillin or other antibiotics ..... Yes No
    c. Aspirin ..... Yes No
    d. Codeine or other narcotics ..... Yes No
    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