The Long Island Group For Headache Management, Ltd

Medical History

300 Garden City Plaza Suite 214
Garden City, NY 11530
(516) 741-1230

Patient Information

Today's Date:_____________________________

First & Last Name:____

Address:____

Phone Numbers: Home___________________________ Cell_________________________ Work________________________

Single_____ Married_____ Widowed____Divorced_____

Sex: M____ F____ Date of Birth:__________________________

Social Security #:____

Email:____

Employer & Address:____

How Did You Hear About Us?: ____

I consent to whatever dental procedures and anesthetics that are considered necessary for the proposed treatment. I also permit the release of any information to or from my physician as may be required. Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. We are allowed to release this information to your insurance company or as necessary to get paid for our services. You can have access to your records by simply asking.

Patient Signature: ____Date:_________________________

Insurance Information

Who is Responsible For This Account?:

____

Relationship to Patient:_________________________

Insurance Company____________________________

Insured's Name:_______________________________

Member ID#:__________________________________

Group #______________________________________

Subscriber's D.O.B:____________________________

Subscriber's Soc. Sec. #:________________________

Secondary Insurance? Yes____ No____

Subscriber's Name_____________________________

Date of Birth_____________ SS#________________

Relationship_________________________________

Insurance Company:___________________________

Group #______________________________________

Insurance Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____________________ and assign directly to Dr. Cary Ganz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. I also give permission for the use of my before and after photographs for educational and marketing purposes.

Patient/ Guardian Name (Print) ___________________________

Patient/Guardian (Signature) ______________________________

Date_________________

In Case Of Emergency, Please Contact: Name ______________________ Relationship______________________

Phone Numbers: Home___________________________ Cell_______________________ Work _____________________

Dental History

Reason For Today's Visit__________________________________ Former Dentist __________________________________

Date of Last Dental Visit ____________________

Do You Have Any Of The Following:

Bad Breath Y N
Bleeding Gums Y N
Blisters (Lips, Mouth, Tongue) Y N
Burning Sensation on tongue Y N
Chew On One Side of Mouth Y N
Cigarette/Cigar Smoking Y N
Clicking/Popping of Jaw Y N
Dry Mouth Y N
Fingernail Biting Y N
Food Collection between Teeth Y N
Foreign Objects Y N
Grinding Teeth Y N
Gums Swollen or Tender Y N
Jaw Pain or Tiredness Y N
Lip or Cheek Biting Y N
Loose Teeth/Broken Fillings Y N
Mouth Breathing Y N
Mouth Pain Y N
Orthodontic Treatment Y N
Pain Around Ear Y N
Periodontal Treatment Y N
Sensitivity to Hot/Cold/Sweets Y N
Sensitivity When Biting Y N
Sores/Growths in Mouth Y N

How Often Do You Floss? ___________________ How Often Do You Brush? ________________________

Health History

Physician's Name & Phone Number ______________________________________ Date of Last Visit___________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phenetermine), Pondimin (fenfkuramine) and Reduc (dexfenfluramine). Yes No

Have You Ever Had Any of the Following:

Abnormal Bleeding Y N
AIDS/HIV Y N
Alcohol/Drug Abuse Y N
Anemia Y N
Arthritis Y N
Artificial Heart Valves Y N
Artificial Joints Y N
Asthma Y N
Back Problems Y N
Blood Disease Y N
Cancer/Tumor/Growth Y N
Cardiac Pacemaker Y N
Chemotherapy Y N
Contact Lenses Y N
Diabetes Y N
Emphysema Y N
Epilepsy Y N
Fainting/Dizziness Y N
Glaucoma Y N
Headaches Y N
Heart Murmur Y N
Heart Problems Y N
Hepatitis (Type?) Y N
Herpes Y N
High Blood Pressure Y N
Jaundice Y N
Jaw Pain Y N
Kidney Disease Y N
Liver Disease Y N
Low Blood Pressure Y N
Mitral Valve Prolapse Y N
Mental/Psychiatric Problems Y N
No Epinephrine Y N
On Coumadin Y N
Pacemaker Y N
Radiation TX Y N
Respiratory Disease Y N
Rheumatic Fever Y N
Shortness of Breath Y N
Sinus Trouble Y N
Special Diet Y N
Stroke Y N
Swollen Feet or Ankles Y N
Thyroid Problems Y N
Tonsillitis Y N
Tuberculosis Y N
Weight Loss (Unexplained) Y N

Women:

Are you Pregnant? Y N If Yes, Due Date:______
Are you Nursing? Y N
Taking Birth Control? Y N

List Any Medications You Currently Take:

Pharmacy Name & Phone:

Allergies:

Aspirin Y N
Sleeping Pills Y N
Codeine Y N
Iodine Y N
Latex Y N
Local Anesthetics Y N
Penicillin Y N
Sulfa Y N
Other: