

10/09

**VALHALLA DENTAL ASSOCIATES**  
50 Legion Drive  
Valhalla, New York 10595

*Paul Hilburg, D.D.S.*

*Jessica Hilburg, D.D.S.*

**PATIENT INFORMATION**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Street Address \_\_\_\_\_

City & State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-mail \_\_\_\_\_ Cell # \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone # \_\_\_\_\_

Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Phone # \_\_\_\_\_

Referred by \_\_\_\_\_

Physician's Name & Address \_\_\_\_\_

**In case of emergency contact:**

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Responsible Party Name \_\_\_\_\_

Address \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

(Please bring in a completed and signed insurance form for our files, if applicable)

Thank you for filling out these forms completely. It will enable us to help you more effectively. If you have any questions, at any time, please ask us. We are happy to help. Please continue on the following pages.

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICAL HISTORY**

Give details of any "YES" answer

1- Have you ever been treated for any disorders such as heart condition, heart murmur, high blood pressure, diabetes, asthma, kidney disease or any other prolonged or chronic condition?  
\_\_\_\_\_

2- Have you ever had any illness or condition other than a common cold, virus or flu, such as mono, hepatitis, etc.?  
\_\_\_\_\_

3- Have you ever had: a) Infective Endocarditis? \_\_\_\_\_  
b) Heart or organ transplant? \_\_\_\_\_  
c) Prosthetic heart valve? \_\_\_\_\_

4- Do you have or have you recently had any evidence of an infection, such as boils, infected wounds, sore throat, or persistent cough?  
\_\_\_\_\_

5- Have you ever been hospitalized?  
\_\_\_\_\_

6- Do you take or have you ever taken any bisphosphonate/bone medicines such as Fosamax or Boniva?  
\_\_\_\_\_

7- What medications are you taking?  
\_\_\_\_\_

8- Are you allergic to any drugs (Penicillin), foods, pollen, materials, etc.?  
\_\_\_\_\_

9- Have you ever had any reaction from any anesthetics?  
\_\_\_\_\_

10- If you are a woman: a) are you pregnant? \_\_\_\_\_  
b) are you nursing? \_\_\_\_\_  
c) are you taking birth control pills? \_\_\_\_\_

11- Are you presently under the care of a physician?  
\_\_\_\_\_

12- Have you ever had any joint replacement (hip, knee, etc,) or have you had any pins surgically placed?  
\_\_\_\_\_

13- Did you have any condition not listed above that we should be aware of?  
\_\_\_\_\_

14- Are you presently in good health?  
\_\_\_\_\_

Reviewed by Doctor \_\_\_\_\_ Date \_\_\_\_\_

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**DENTAL HISTORY**

Last Dental Visit \_\_\_\_\_

Purpose of this visit \_\_\_\_\_

Give details of any "YES" answer

1- Are you having pain in any of your teeth?

\_\_\_\_\_

2- Do you have sensitivity to hot or cold?

\_\_\_\_\_

3- Do your gums bleed?

\_\_\_\_\_

4- Have you ever had any illness or complication following any dental treatment?

\_\_\_\_\_

5- Have you ever had prolonged bleeding from injury, tooth extraction, etc.?

\_\_\_\_\_

6- Is snoring a problem for you or any member of your family?

\_\_\_\_\_

7- What is your present oral hygiene routine?

a) how *often* do you brush your teeth? \_\_\_\_\_

b) how *often* do you floss? \_\_\_\_\_

c) other \_\_\_\_\_

8- Do you participate in any sports which may endanger your teeth?

\_\_\_\_\_

9- Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_

Have you ever smoked? \_\_\_\_\_

Remarks:

Reviewed by Doctor \_\_\_\_\_ Date \_\_\_\_\_

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**COSMETIC DENTISTRY QUESTIONNAIRE**

**Circle One**

- |   |     |    |
|---|-----|----|
| 1) Do you want your teeth to be whiter?   | Yes | No |
| 2) Do you want your gums to look better?  | Yes | No |
| 3) Do you want to show more or fewer teeth when you smile?                              | Yes | No |
| 4) Do you think you show too much or too little gum when you smile?                     | Yes | No |
| 5) Do you want to have longer or shorter teeth?   | Yes | No |
| 6) Would you prefer wider or narrower teeth?  | Yes | No |
| 7) Do you wish your teeth were shaped or positioned differently?                        | Yes | No |
| 8) Does your self-confidence decrease when you smile?                                   | Yes | No |
| 9) Do you ever try to cover your smile?   | Yes | No |
| 10) When you look in the mirror, do you see minor defects in your gums or in any teeth? | Yes | No |

**TMD SCREENING QUESTIONNAIRE**

- |   |     |    |
|---|-----|----|
| 1) Do you suffer from frequent headaches? (more than once a week)   | Yes | No |
| 2) Do you ever have pain, discomfort or other sensations, such as ringing, roaring, stuffiness, etc. around the ears, temples, neck or cheek? | Yes | No |
| 3) Does it ever hurt to chew?   | Yes | No |
| 4) Does it ever hurt to open wide, take a big bite or yawn?   | Yes | No |
| 5) Does your jaw ever make popping, cracking or grating noises?   | Yes | No |
| 6) Does your jaw ever lock?   | Yes | No |

In an effort to provide our patients with flexible payment plans, we offer several options. Payment arrangements are requested at the time of your visit.

We offer the following options:

Payment by cash \_\_\_\_\_

Payment by check \_\_\_\_\_

Payment by credit card \_\_\_\_\_

Automatic monthly billing to  
your Visa or MasterCard \_\_\_\_\_

Health Care Credit Card \_\_\_\_\_

Please choose whichever option works best for you, sign below and return to the front desk before your visit.

If none of the above apply, please see the receptionist at the front desk. Thank you.

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Please choose your preferred method of contact:

\_\_\_ E-mail

\_\_\_ Cell phone text message

\_\_\_ Cell phone voice mail

\_\_\_ Home phone

\_\_\_ Business phone



Jessica Hilburg, D.D.S. and Paul Hilburg, D.D.S.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_,  
have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Optional: You may discuss my dental condition with my Parent/Child: \_\_\_\_\_  
Name

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



For office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,  
but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (please specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_