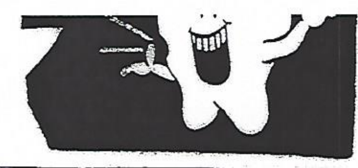
44 S. Central Ave.
Valley Stream, NY 11580
(516) 561-1151 (Fax) 561-1447

Harry Satin, D.D.S.
Hsdds @ optonline.net



REGISTRATION FORM

Patient's full name: ______ * Your E-mail: ______
Address: ______ City/State/Zip: ______
Home phone: ______ Birthdate ______ Sex: ______
Work phone: ______ Ext. ______ Marital status ______
Employer: ______ Occupation ______
Employer's address: ______
Social Security #: ______
Will this visit be: Insurance ______ Check/CASH ______ Credit Card ______
Responsible Party's information if other than patient: ______
Name: ______
Relationship to patient: ______
Address: ______ City/State/Zip ______
Home phone: ______ Birthdate ______ Sex: ______
Work phone: ______
Employer: ______ Employer's Address: ______
Insured person's social security: ______

Dental information:
Purpose of today's visit? ______
Are you in pain? ______ Had you had swelling? ______
Is pain due to accident or trauma? ______
When was your last dental examination? ______
When was your last full series x-rays? ______ Last ? ______

Do you or your spouse have dental insurance? ______ Self? ______ Spouse? ______
Physician's name: ______ Phone # ______
Date of last physical exam: ______ Do you smoke? ______
How is your health? Excellent ______ Good ______ Fair ______ Poor: ______
Are you being treated for anything now? ______ If yes, what? ______
Are you taking any medications? ______ If yes, what? ______
Have you had surgery in the last 5 years? ______ If yes, what? ______
Do you have a history of high blood pressure? ______
Are you allergic to penicillin or any other? ______ Please list ______
*Do you need to premedicate?

LIST MEDICATIONS HERE:
1. ______
2. ______
3. ______
4. ______

Have you ever had any of the following?

Rheumatic fever? ______
Anemia? ______
Venereal disease? ______
Heart trouble? ______
Are you pregnant? ______

Kidney Disease? ______
Hepatitis? ______
Tuberculosis? ______
AIDS or HIV? ______
If so, what month? ______

Liver Disease? ______
Asthma? ______
Diabetes? ______
Epilepsy? ______
*HIP, Knee, or Valve replacement?

Is there anything else we should know about your health? ______

IN CASE OF EMERGENCY PLEASE CONTACT:
Name: ______ Phone # ______ Relationship: ______

fee is charged for broken appointments without 24 hours notice

How were you referred to this office? ______

I hereby give consent for treatment and understand that I am financially responsible for all charges.

Signature: ______ Date ______