CLARKSTOWN DENTAL PLLC

Today's Date: _____

Patient's Legal Name: _____ Date of Birth: _____

Age: _____

Home address: _____ Home Phone:

_____

E-mail: _____Cell Phone: _____ Confirmation Reminder

(Email /Cell / Both)

Social Security #: _____ Single: ____ Married: ____ Widowed: ____ Separated: ____

Divorced: ____

Male: ___ Female: ____ Patient Employed By: _____ Occupation:

_____

Emergency Contact & Telephone #:

_____

Who may we thank for referring you?

_____

Who will be responsible for your account? (*Please circle*) Self Spouse Father Mother Other:

_____

(If self, skip to the next section)

Name _____ S.S. # _____ Date of Birth

_____

Home Telephone Number: _____ Cell Telephone Number:

_____

Home Address:

_____

Employer: _____ Business Telephone Number:

_____

Check yes or no whether you have had any of the following:

( ) Y ( ) N Anaphylaxis
( ) Y ( ) N AIDS/HIV Positive
( ) Y ( ) N Anemia
( ) Y ( ) N Arthritis, Rheumatism
( ) Y ( ) N Artificial / **( )** Replacement Joints
( ) Y ( ) N Artificial heart valves
( ) Y ( ) N Asthma
( ) Y ( ) N Atopic (allergy prone)
( ) Y ( ) N Autoimmune disorders – Please specify below:
( ) Multiple Sclerosis **( )** Lupus **( )** Fibromyalgia **( )** other _____
( ) Y ( ) N Back Problems
( ) Y ( ) N Blood disease
( ) Y ( ) N Blood Transfusion
( ) Y ( ) N ( ) Cancer
( ) Y ( ) N Chemotherapy
( ) Y ( ) N Chemical dependency
( ) Y ( ) N Circulatory problems
( ) Y ( ) N Cortisone treatment
( ) Y ( ) N Cough, persistent / blood
( ) Y ( ) N Diabetes (Type: _____)

Please complete both sides

( ) Y ( ) N Epilepsy
( ) Y ( ) N Fainting
( ) Y ( ) N Food allergies
( ) Y ( ) N Fever Blisters / Herpes
( ) Y ( ) N Severe/Frequent Headaches
( ) Y ( ) N Hemophilia / Abnormal Bleeding
( ) Y ( ) N High / **( )** Low Blood Pressure
( ) Y ( ) N Jaw Pain
( ) Y ( ) N Kidney Problems
( ) Y ( ) N Neurological disorders

( ) Y ( ) N Psychiatric Problems
( ) Y ( ) N Seizures
( ) Y ( ) N Shingles
( ) Y ( ) N Swelling of feet or ankles
( ) Y ( ) N Thyroid disease or malfunction
( ) Y ( ) N Tonsillitis

( ) Y ( ) N Tuberculosis
( ) Y ( ) N Venereal Disease

( ) Y ( ) N Ulcers / **( )** Colitis

Cardiac Conditions:

( ) Y ( ) N Artificial Heart Valves
( ) Y ( ) N Heart Attack
( ) Y ( ) N Heart Surgery
( ) Y ( ) N Pacemaker

( ) Y ( ) N Congenital Heart Defects
( ) Y ( ) N Heart Murmur
( ) Y ( ) N Mitral Valve Prolapse
( ) Y ( ) N Rheumatic / **( )** Scarlet Fever

( ) Y ( ) N Stents

( ) Y ( ) N Stroke

Respiratory Conditions:

( ) Y ( ) N Asthma
( ) Y ( ) N Allergies (Latex / Medications / Food) *Please specify*:

_____
( ) Y ( ) N Emphysema
( ) Y ( ) N Sinus Problems *If yes, please list*:

_____
( ) Y ( ) N Smoking

( ) Y ( ) N Tuberculosis

Are you currently taking any medications? If yes, list all:

_____

_____

_____

Do you have any drug allergies? *If yes, list all*:

_____

Women: Are you pregnant? **( ) Y ( ) N** Nursing? **( ) Y ( ) N** Taking birth control pills? **( ) Y ( ) N**

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

Signature of patient: _____ Date:

_____

Reviewed by: _____