

# 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:

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Home Address:

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Employer: \_\_\_\_\_ Business Telephone Number:

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

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

*Please complete both sides*

- |  |  |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy   | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies                                     | <input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters / Herpes    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Severe/Frequent Headaches                          | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia / Abnormal      |
| Bleeding   |  |
| <input type="checkbox"/> Y <input type="checkbox"/> N High / <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw Pain                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems                                    | <input type="checkbox"/> Y <input type="checkbox"/> N Neurological disorders     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems                               | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Shingles   | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction                     | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis                |

Y  N Tuberculosis

Y  N Ulcers /  Colitis

Y  N Venereal Disease

**Cardiac Conditions:**

Y  N Artificial Heart Valves

Y  N Congenital Heart Defects

Y  N Heart Attack

Y  N Heart Murmur

Y  N Heart Surgery

Y  N Mitral Valve Prolapse

Y  N Pacemaker

Y  N Rheumatic /  Scarlet Fever

Y  N Stents

Y  N Stroke

**Respiratory Conditions:**

Y  N Asthma

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

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 Y  N Emphysema

Y  N Sinus Problems *If yes, please list.*

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 Y  N Smoking

Y  N Tuberculosis

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

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

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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: \_\_\_\_\_