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(212) 888-4140

20 STUDIO ARCADE
BRONXVILLE, NEW YORK 10708
(914) 337-6536

Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____ Title: _____

Home Address: _____

City, State & Zip Code: _____

Home Phone: _____ **Work Phone: _____**

Cell Phone: _____ **E-mail Address: _____**

Social Security #: _____ **Date of Birth: _____**

Sex: Male / Female **Marital Status:** Single/Married/Divorced/Widowed

Employed By: _____ **Occupation: _____**

Business Address: _____

City, State & Zip Code: _____

Insured's Name: _____ **Employed By: _____**

Insured's SS#: _____ **Insured's Date of Birth: _____**

Referred By: _____

Person Responsible for Account: _____

Method of Payment:

Check Cash MasterCard ® Visa ® Discover ® American Express

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

Medical History

Medical Doctor: _____ Phone Number: _____ Date of Last Visit _____

Previous Dentist: _____ Phone Number: _____ Date of Last Visit _____

Cardiac :	**Yes**	**No**	**Date**		**Yes**	**No**	**Date**
Rheumatic Fever				Heart Attack			
Congenital Heart Disease				Heart Failure			
Heart Murmur				Abnormal Heart Rhythm			
Mitral Valve Prolapse				Pacemaker Insertion			
Angina				Heart Surgery			
High Blood Pressure							

General :	**Yes**	**No**	**Date**		**Yes**	**No**	**Date**
Diabetes				Epilepsy			
Hepatitis (type:_____)				Tuberculosis			
Stroke				Herpes			
Asthma				AIDS			
Anemia				Cancer			
Bleeding Problems							

Allergy :	**Yes**	**No**	**Date**		**Yes**	**No**	**Date**
Penicillin				Other Antibiotics			
Other Antibiotics				Other (_____)			

AT PRESENT, ARE YOU OR HAVE YOU EVER BEEN:

	Yes	**No**	**Date**	**Type**
1. Under medical care for a specific problem?				
2. Taking any medication?				
3. Wearing a prosthetic implant (e.g., hip)?				
4. Pregnant or anticipating becoming pregnant?				

Dental History

1. Are your teeth sensitive to? (circle one): HOT COLD SWEETS PRESSURE

	Yes	**No**		**Yes**	**No**
2. Do your gums bleed while brushing or flossing?			5. Do you clench or grind your teeth?		
3. Do you have any sores or lumps in or near your mouth?			6. Have you had any orthodontic treatment?		
4. Have you had any head, neck or jaw injuries?			7. Do you floss after brushing?		

IN CASE OF EMERGENCY, WHOM DO WE CALL?

Name: _____ Phone Number: _____ Relationship: _____

_____

Signature and Date