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 Anemia
( ) Y ( ) N Artificial / ( ) Replacement Joints
( ) Y ( ) N Asthma
( ) Y ( ) N Autoimmune disorders – Please specify below:
( ) Multiple Sclerosis ( ) Lupus ( ) Fibromyalgia ( ) other _____
( ) Y ( ) N Back Problems
( ) Y ( ) N Blood Transfusion
( ) Y ( ) N Chemotherapy
( ) Y ( ) N Circulatory problems
( ) Y ( ) N Cough, persistent / blood
( ) Y ( ) N Covid 19, had virus
( ) Y ( ) N Covid 19 full vaccination
( ) Y ( ) N AIDS/HIV Positive
( ) Y ( ) N Arthritis, Rheumatism
( ) Y ( ) N Artificial heart valves
( ) Y ( ) N Atopic (allergy prone)
( ) Y ( ) N Blood disease
( ) Y ( ) N Cancer
( ) Y ( ) N Chemical dependency
( ) Y ( ) N Cortisone treatment
( ) Y ( ) N Diabetes (Type: _____)

Please complete both sides

( ) Y ( ) N Epilepsy
( ) Y ( ) N Food allergies
( ) Y ( ) N Severe/Frequent Headaches
( ) Y ( ) N High / ( ) Low Blood Pressure
( ) Y ( ) N Kidney Problems
( ) Y ( ) N Psychiatric Care
( ) Y ( ) N Shingles
( ) Y ( ) N Thyroid disease or malfunction
( ) Y ( ) N Tuberculosis
( ) Y ( ) N Venereal Disease
( ) Y ( ) N Fainting
( ) Y ( ) N Fever Blisters / Herpes
( ) Y ( ) N Hemophilia / Abnormal Bleeding
( ) Y ( ) N Jaw Pain
( ) Y ( ) N Neurological disorders
( ) Y ( ) N Seizures
( ) Y ( ) N Swelling of feet or ankles
( ) Y ( ) N Tonsillitis
( ) Y ( ) N Ulcers / ( ) Colitis

Cardiac Conditions:

( ) Y ( ) N Artificial Heart Valves
( ) Y ( ) N Heart Attack
( ) Y ( ) N Heart Surgery
( ) Y ( ) N Pacemaker
( ) Y ( ) N Stents
( ) Y ( ) N Congenital Heart Defects
( ) Y ( ) N Heart Murmur
( ) Y ( ) N Mitral Valve Prolapse
( ) Y ( ) N Rheumatic / ( ) Scarlet Fever
( ) Y ( ) N Stroke

Respiratory Conditions:

( ) Y ( ) N Asthma
( ) Y ( ) N Allergies (Latex / Medications / Food) *Please specify*: _____
( ) Y ( ) N Emphysema
( ) Y ( ) N Sinus Problems
( ) Y ( ) N Smoking
If yes, please list: _____
( ) 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: _____