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 984 North Broadway
 Yonkers, NY 10701

Patient Name _____ Date of Birth _____ Married _____ Single _____

Parent or Guardian _____ Name of Spouse _____

Address _____

Home Phone Number _____ Work Phone Number _____

Cell Phone Number _____ Email Address _____

Occupation _____ Position _____ How long held? _____

Employer _____ Address _____

Spouse's Occupation _____ Position _____ How long held? _____

Patient's Social Security Number _____

Spouse's Social Security Number _____

Who may we thank for the referral? _____

Who will pay this account? _____

Name of Dental Insurance Company and Policy Number _____

Purpose of Visit _____

- | | | |
|---|-------|------|
| 1. Are you happy with the appearance of your teeth? | Yes__ | No__ |
| 2. Would you like to learn more about cosmetic dentistry? | Yes__ | No__ |
| 3. Do you feel nervous about dental treatment? | Yes__ | No__ |
| 4. Have you been a patient in the hospital in the past two years? | Yes__ | No__ |
| 5. Have you seen a physician in the last two years? | Yes__ | No__ |
| 6. Are you allergic to any medications including aspirin, penicillin, codeine, dental injections? | Yes__ | No__ |
7. Circle any of the following which you have had or have at the present

- | | | | |
|---------------------------|---------------------------------|------------------------|------------------|
| Bacterial Endocarditis | Hemophilia | Radiation Treatment | Diabetes |
| Heart Murmur | Blood Disease | Arthritis (Rheumatism) | Kidney Problems |
| Irregular Heart Beat | Sickle Cell Anemia | Neurological Problems | Dialysis |
| High Blood Pressure | Anemia | Hepatitis A | Liver Problems |
| Low Blood Pressure | Excessive Bleeding | Hepatitis B | Hepatitis C |
| Rheumatic Heart Fever | Asthma | Epilepsy or Seizures | Stroke |
| Rheumatic Heart Disease | Respiratory Disease | Psychiatric Problems | Thyroid Disease |
| Artificial Heart Valve(s) | Shortness of Breath | Emotional Problems | Ulcer/Colitis |
| Congenital Heart Lesion | Hay Fever | Alcoholism | Sinus Problems |
| Mitral Valve Prolapse | Tuberculosis | Fever Blisters | Herpes |
| Heart Attack _____ Year | Sexually Trans.Disease | Cortisone | Drug Addiction |
| Angina/Chest Pain | Glaucoma | Malignancies | AIDS |
| Heart Pacemaker | Cancers,Tumors,Growths | Oral Contraceptives | Pregnant__Month |
| Heart Surgery | Immunosuppressive Disorders/ARC | | Artificial Joint |
| Congestive Heart Failure | Chemotherapy | Anticoagulants | Replacement |

