PROSTHODONTIC ASSOCIATES OF LONG ISLAND, P.C.

(CONFIDENTIAL INFORMATION FOR YOUR FILE)

WELCOME!

Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at any time, please ask up. We will be happy to help. Please Print.

PERSONAL INFORMATION

NAME ____________________ EMAIL ADDRESS ____________________

HOME PHONE ( ) ____________ BUSINESS ( ) ____________ CELL ( ) ____________

ADDRESS ____________ CITY ____________ STATE ____________ ZIP ____________

SOC. SEC NO. ____________ DATE OF BIRTH ____________

OCCUPATION ____________________

EMERGENCY CONTACT/RELATIONSHIP ____________________ PHONE ( ) ____________

REFERRED BY ____________________

REASON FOR THIS VISIT? ____________ **ARE YOU CURRENTLY IN PAIN** YES ❑ NO ❑

IF SO, EXPLAIN: ____________________

MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

HEART		
Coronary Artery Disease/Angina	YES ❑	NO ❑
Heart Attack (MI)	YES ❑	NO ❑
Congestive Heart Failure	YES ❑	NO ❑
Heart Murmur/Mitral Valve Prolapse	YES ❑	NO ❑
Rheumatic Heart Disease	YES ❑	NO ❑
Heart Surgery	YES ❑	NO ❑
Pacemaker	YES ❑	NO ❑
Heart Valve/Damaged Valve	YES ❑	NO ❑
Congenital Heart Defect	YES ❑	NO ❑
Low or High Blood Pressure	YES ❑	NO ❑
LUNGS		
Asthma	YES ❑	NO ❑
Chronic Bronchitis/Emphysema	YES ❑	NO ❑
Tuberculosis	YES ❑	NO ❑
ENDOCRINE		
Diabetes	YES ❑	NO ❑
Hypothyroidism	YES ❑	NO ❑
Adrenal Insufficiency	YES ❑	NO ❑
MUSCULOSKELETAL		
Arthritis/Gout	YES ❑	NO ❑
Systemic Lupus Erythematosus	YES ❑	NO ❑
Artificial Bones or Joints	YES ❑	NO ❑
CANCER		
Chemotherapy	YES ❑	NO ❑
Radiation	YES ❑	NO ❑
Surgery	YES ❑	NO ❑

LIVER DISEASE		
Hepatitis/Jaundice	YES ❑	NO ❑
INFECTIOUS DISEASE		
Sexually transmitted disease	YES ❑	NO ❑
AIDS or HIV infection	YES ❑	NO ❑
Rheumatic Fever	YES ❑	NO ❑
BLOOD DISEASE/BLEEDING PROBLEMS		
Anemia	YES ❑	NO ❑
Abnormal bleeding	YES ❑	NO ❑
Hemophilia	YES ❑	NO ❑
Blood transfusion	YES ❑	NO ❑
GASTROINTESTINAL		
Ulcers/GERD	YES ❑	NO ❑
NEUROLOGIC		
Epilepsy/Seizures	YES ❑	NO ❑
Fainting spells/Dizziness	YES ❑	NO ❑
Stroke	YES ❑	NO ❑
Parkinson's Disease	YES ❑	NO ❑
Multiple Sclerosis	YES ❑	NO ❑
Mental health problems	YES ❑	NO ❑
RENAL		
Kidney Infection	YES ❑	NO ❑
Dialysis	YES ❑	NO ❑
Renal transplant	YES ❑	NO ❑
HEAD, EARS, EYES, NOSE AND THROAT		
Sinus problems	YES ❑	NO ❑
Hoarseness/Trouble swallowing	YES ❑	NO ❑

OVER ☛

WOMEN

Are you pregnant? YES ❑ NO ❑
Are you nursing? YES ❑ NO ❑
Are you taking hormones? YES ❑ NO ❑

CURRENT MEDICATIONS (PRESCRIPTIONS AND NON-PRESCRIPTION)

1. ______ 2. ______

3. ______ 4. ______

5. ______ 6. ______

ARE YOU ALLERGIC OR EVER HAD A REACTION TO:

Local Anesthetics YES ❑ NO ❑ Penicillin YES ❑ NO ❑ Aspirin YES ❑ NO ❑

Erythromycin YES ❑ NO ❑ Codeine YES ❑ NO ❑ Sulfa YES ❑ NO ❑

Other ______

NAME AND ADDRESS OF MY PHYSICIAN IS:

______

Have you had any operation, illness or been hospitalized in the past five years? YES ❑ NO ❑

If so, what was the illness or problem? ______

SOCIAL HISTORY (CHECK ALL APPROPRIATE ANSWERS)

Tobacco Usage: Cigarettes ❑ Packs per day? Cigar ❑ Number of years? Pipe ❑ How often?

Alcohol Usage: Social ❑ Daily ❑ Heavy ❑

Beer ❑ Wine ❑ Liquor ❑

DENTAL HISTORY

Last Dental visit? ______
Your current dental heath is: Fair ❑ Good ❑ Poor ❑
Have you ever experienced a problem with a local anesthetic? YES ❑ NO ❑
Have you ever had TMJ treatment? YES ❑ NO ❑
Have you ever had braces? YES ❑ NO ❑
Have you ever been diagnosed or treated for periodontal disease? YES ❑ NO ❑
Have you ever had any problems associated with any previous dental work? YES ❑ NO ❑
If so, what? ______

______

Do you need to premedicate prior to dental work? YES ❑ NO ❑
Do your gums bleed? YES ❑ NO ❑
Do you like your smile? YES ❑ NO ❑
If not, what would you change? ______

______

Are your teeth sensitive to hot and cold? YES ❑ NO ❑
Have you lost any teeth? YES ❑ NO ❑
If so, why? ______
Are any of your teeth loose? YES ❑ NO ❑
Please describe your chief dental concerns: ______

______

______

The information given about my health history in this form is accurate to the best of my knowledge.
I hereby give consent to perform necessary diagnostic tests and an evaluation on my dental health.
I understand that I am responsible for payment.
Payment is expected as services are rendered.

Signature of Patient ______ **Date:** ______

Signature of Dentist ______ **Date:** ______