East Village Dental Centre

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Patient Information

Today's Date:_____

Name:_____ ☐ Male ☐ Female

Birthdate:___/___/____ Age:_____ S.S. #:_____ Driver's License #:_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address:_____City:_____State:_____Zip:_____

Phone:(_____)_____ Cell:(_____)_____ Work:(_____)_____

E-mail:_____

Occupation: _____Employer:_____ How Long?_____

Whom may we thank for referring you? _____

☐ Yellow Pages ☐ 1-800 Dentist ☐ Front Sign ☐ Insurance Website ☐ Internet Search (Google/Yahoo)

*Do you remember the term used when searching?*_____

Person to Contact in Case of Emergency

His/Her Name:_____ Relation:_____ Phone:_____

Preferred payment method: ☐ Cash ☐ Check ☐ Credit Card ☐ Financing ☐ Dental Insurance

Dental History

Why have you come to the dentist today? _____

_____

Previous Dentist/Location:_____ Date of Last Exam:_____

Why did you leave your previous dentist?_____

	YES	NO
Are you currently in pain?	☐	☐
Do your gums bleed?	☐	☐
Do you clench or grind your teeth?	☐	☐
Are your teeth sensitive to heat /cold?	☐	☐
Do you wear dentures or partials?	☐	☐
Are you interested in learning about dental implants?	☐	☐
Are you happy with your smile?	☐	☐

If not, what would you change_____

CONTINUED ON BACK

Medical History

Do you have a personal physician?..... ☐ Yes ☐ No

Physician:_____ Phone:_____ Date of Last Exam:_____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician?..... ☐ Yes ☐ No

If yes, please explain:_____

Do you smoke or use tobacco in any other form?..... ☐ Yes ☐ No

Women Only:

Are you pregnant or think you may be pregnant?..... ☐ Yes ☐ No

Are you nursing?..... ☐ Yes ☐ No

Are you taking birth control pills?..... ☐ Yes ☐ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry/Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Local Anesthetics -Novocain	Y N Penicillin	Y N Other

Please list additional drugs/materials that cause allergic reactions:_____

Are you taking any medication(s) including non-prescription medicine?..... ☐ Yes ☐ No

If yes, what medication(s) are you taking?_____

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?..... ☐ Yes ☐ No

Have you been hospitalized for any reason within the last 5 years?..... ☐ Yes ☐ No

If yes, please explain:_____

Do you have or have you had any of the following?

Y N Abnormal Bleeding	Y N Congenital Heart Defect	Y N Heart Surgery	Y N Radiation Treatment
Y N Alcohol Abuse	Y N Diabetes	Y N Hemophilia	Y N Rheumatic Fever
Y N Anemia	Y N Difficulty Breathing	Y N Hepatitis	Y N Seizures
Y N Arthritis	Y N Drug Abuse	Y N Herpes	Y N Sickle Cell Disease
Y N Artificial Bones/Joints	Y N Emphysema	Y N High Blood Pressure	Y N Sinus Problems
Y N Artificial Valves	Y N Epilepsy	Y N HIV+/AIDS	Y N Steroid Therapy
Y N Asthma	Y N Fainting Spells	Y N Kidney Problems	Y N Stroke
Y N Blood Transfusion	Y N Glaucoma	Y N Liver Disease	Y N Thyroid Problems
Y N Bruise Easily	Y N Hay Fever	Y N Low Blood Pressure	Y N Tonsillitis
Y N Cancer	Y N Headaches	Y N Mitral Valve Prolapse	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Heart Attack	Y N Pacemaker	Y N Ulcers
Y N Colitis	Y N Heart Murmur	Y N Psychiatric Problems	Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced:_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that I am responsible for payment of services rendered. I have read and do hereby consent and acknowledge my agreement to the terms set forth in the NOTICE OF PRIVACY PRACTICES.

X_____

Signature of patient (or parent/guardian if minor) **Date**