



Dentistry for Adults & Adolescents

62 Second Place
Brooklyn, NY 11231

718-625-7147
reception@southbrooklyndentist.com

GENERAL INFORMATION

Title (Check one): Dr. Mr. Mrs. Ms. Marital Status: Single Married Divorced Widowed Other

First Name: Last Name:

Address:

City, State, Zip:

Home Telephone: Work Telephone:

Cellular Telephone: Email Address:

Preferred Contact Method: May We Send Text Confirmations: YES NO

Occupation: Employer:

Referred by:

Family Physician Name & Telephone:

PERSONAL INFORMATION

Date of Birth: Age:

Social Security No:

DENTAL INSURANCE INFORMATION

Subscriber's Name: Subscriber's Social Security No:

Subscriber's Date of Birth: Subscriber's Employer:

Insurance Carrier: Phone Number:

Subscriber/Member ID: Group Number:

Relationship to Subscriber:

IN CASE OF EMERGENCY

Name & Relationship to Contact:

Telephone Number:

MEDICAL INFORMATION

Are you in good health?	Y	N
Has there been any change in your general health in the past year? If yes, Please explain:	Y	N
Do you smoke? How Much?	Y	N
Have you had any serious illness, operations, or hospitalizations? If yes, Please explain:	Y	N
Have you ever had intravenous sedation or general anesthesia?	Y	N
Were there adverse effects? If yes, Please explain:	Y	N
Have you ever had difficulty tolerating a dental procedure? If yes, Please explain:	Y	N

Do you have?

AIDS/HIV	Y	N
ANEMIA	Y	N
ANGINA	Y	N
ARTHRITIS	Y	N
ASTHMA	Y	N
BISOPHOSPHONATE THERAPY (BONE DENSITY TREATMENT)	Y	N
BLEEDING PROBLEMS/TAKING BLOOD THINNERS	Y	N
CANCER	Y	N
CHEMO/RADIATION	Y	N
COSMETIC SURGERY	Y	N
DIABETES: TYPE 1 TYPE 2	Y	N
DIZZY SPELLS/FAINTING	Y	N
DRUG ADDICTION	Y	N
EPILEPSY	Y	N
GLAUCOMA	Y	N
HEART CONDITION: If yes, please explain:	Y	N
HEPATITS:	Y	N
HIGH OR LOW BLOOD PRESSURE	Y	N
JOINT REPLACEMENT	Y	N

KIDNEY DISEASE	Y	N
LIVER DISEASE	Y	N
LUNG DISEASE	Y	N
PSYCHIATRIC CARE	Y	N
RHEUMATIC FEVER	Y	N
SINUS TROUBLE	Y	N
SLEEP APNEA	Y	N
TOBACCO USE	Y	N
STROKE	Y	N
THYROID PROBLEMS: HYPO HYPER	Y	N
TMJ/TMD	Y	N
VENEREAL DISEASE	Y	N
Any disease, drug or transplant operation that has depressed your immune system?	Y	N
Recurrent infections of any kind? If yes, please list:	Y	N

ALLERGIES

Penicillin?	Y	N
Latex?	Y	N
List other allergies here:	Y	N

ADDITIONAL INFORMATION

Are you taking birth control pills?	Y	N
Are you pregnant, trying to become pregnant, or any chance you might be pregnant now?	Y	N
Are you breast feeding?	Y	N
Are you taking hormone replacement?	Y	N
Do you have a dental problem that require immediate attention?	Y	N
Do your gums bleed? If so, describe:	Y	N
Have you noticed any loose teeth? Describe:	Y	N
Have you had previous periodontal treatment? Describe:	Y	N
Have you ever had orthodontic treatment (braces):	Y	N

In order to provide the best possible care, please list any other conditions that may affect your dental treatment including phobias, adverse dental experiences, or conditions that may make dental treatment difficult:

PLEASE LIST ALL CURRENT MEDICATIONS HERE:

By signing below, I certify that all information is true and correct, to the best of my knowledge.

SIGNATURE: _____

DATE: _____