

Date: _____



First Name	MI	Last Name	D.O.B	Home Phone	
Address		City	State	Zip	
Social Security	Driver's License		Sex	Marital Status	
Cell Phone	Spouse's Name				

Employment Information

Occupation	Employer	Employer Address		
Employer City	State	Zip	E-mail Address	
Alternative E-mail	Work Phone	Work Fax	Alternative Phone	

Emergency Information

Emergency Contact Name	Relationship	Phone Number
Cell Phone		

Referral Information

May We Thank Someone For Your Referral?	Other Referral Source
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Person Responsible for Payment (f Other Than Patient)

First Name	Last Name	Social Security	Driver's License	
Address		City	State	Zip
Occupation	Employer	Length of Employment		
Employer Address	City	State	Zip	Employer Phone

NORTHERN WESTCHESTER DENTAL CENTER
3505 Hill Boulevard, Suite F, Yorktown Heights, NY 10598
Telephone 914.245.3103 Facsimile 914.245.3216
www.NWDentist.com

Insurance Informatior

	Primary Carrier	Secondary Carrier
Name of Employee		
Employee's D.O.B.		
Employee's Social Security		
Name of Employer		
Insurance Company		
Insurance Company Address and Phone Number		
Coverage Effective Date		
Group/Policy Number		

Health History

It is important that we know your Medical and Dental History. These Facts have a direct bearing on your dental health. We thank you for your time to fill this in as completely as possible.

Check the Appropriate Answer

Yes No

		Are you in pain now? If yes please describe below
		Is your general health good?
		Has there been a change in your health in the past year?
		Have you ever been hospitalized or had a serious injury in the last three years?
		Are you being treated by a physician now?
		Have you had any problems with prior dental treatment?

If you have answered yes to any of the above questions please explain below.

Please list all surgeries and hospitalizations

	Date:
	Date:
	Date:

Please list any current medications and/ or drugs you are taking (please include any non-Prescription vitamins & health supplements)

Please list any medications and/ or drugs you have become sick from or have shown an allergic reaction to:

HAVE YOU EVER EXPERIENCED:

YES	NO	
		Chest Pain?
		Swollen ankles?
		Shortness of Breath?
		Recent Weight loss, fever, night sweats?
		Persistent cough, coughing up blood?
		Bleeding problems, bruising easily?
		Sinus problems?
		Difficulty Swallowing?
		Diarrhea, constipation, bloody stool?
		Frequent vomiting, nausea?
		Dry mouth?
		Anxiety, panic attacks?

YES	NO	
		Angina?
		Ringing in Ears?
		Headaches?
		Fainting Spells?
		Blurred vision?
		Seizures, Epilepsy?
		Excessive thirst?
		Frequent urination?
		Difficulty urinating?
		Jaundice?
		Joint pain, stiffness?
		Dizziness?

DO YOU HAVE OR HAVE YOU EVER HAD:

YES	NO	
		Heart Diseased?
		Heart murmurs, mitral valve prolapse?
		Stroke, hardening of arteries?
		Hepatitis, other liver disease?
		Head injury?
		AIDS/ HIV/ Immune Disease?
		Arthritis. Rheumatism?
		Skin diseases?
		VD (syphilis or gonorrhoea)?
		Kidney, bladder disease?
		Allergies (food/meds/latex)
		Family history or diabetes or tumors?
		Organ transplant

YES	NO	
		Heart attack?
		Rheumatic fever?
		High blood pressure?
		Stomache problems?
		Cold sores?
		Tumors, cancer?
		Eye diseases?
		Anemia?
		Herpes?
		Thyroid disease?
		Diabetes?
		Asthma or TB?
		Emphysema or other lung disease?

HAVE YOU EVER BEEN TREATED WITH:

YES	NO	
		Pschiatric care?
		Radiation treatment?
		Prosthetic heart valve?
		Artificial joints?

YES	NO	
		Blood transfusions?
		Chemotherapy?
		Pacemaker?
		Artificial prosthesis (implant)?

RE YOU TAKING OR HAVE YOU EVER TAKE

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Recreational drugs?
Fen-Phen, Redux, Steroids,
Cortizone

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Alcohol?
Tobacco?

If you have taken and quit any of the above please indicate when: _____

All Patients:

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Do you wear corrective lenses?
Do you have or have you had
any medical problems NOT listed on this form?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

Do you wear contact lenses?

If yes please explain. _____

CHECK APPROPRIATE ANSWER:

Do you experience sensitivity to:

Hot	Cold	Sweets
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had an injury to your face, neck, or jaw? If yes please explain.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Do you grind your teeth?

<input type="checkbox"/>	<input type="checkbox"/>
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Have you ever had "clicking" or "popping" in your ears when you chew?

<input type="checkbox"/>	<input type="checkbox"/>
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Do your gums bleed?

<input type="checkbox"/>	<input type="checkbox"/>
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Have you had gum (periodontol) surgery?

<input type="checkbox"/>	<input type="checkbox"/>
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Have you had an unfavorable experience from local anesthetics?

<input type="checkbox"/>	<input type="checkbox"/>
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Have you ever had orthodontic appliances i.e. braces?

<input type="checkbox"/>	<input type="checkbox"/>
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Is there anything you would like to discuss further with the Dentist?

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/ or medication.

Patient Signature _____ Date: _____

Consent

I confirm as true the above health information. I hereby authorize the dentist to take x-rays, study molds, photographs, or any aids deemed appropriate by the dentist in charge of my care to make a thorough diagnosis of my dental needs. I also authorize the dentist to perform any and all forms of treatment, medication, and therapy that may be necessary for my dental health.

Patient Signature _____ Date: _____

Cancellation Policy

I am aware that Northern Westchester Dental Center sets aside dedicated time for each appointment to better serve the needs of the patients. If I am not able to meet my appointment I agree to give at least 48 hours notice. I understand that if I fail to notify the staff within this time frame, I will be charged for the period of time set aside for me.

Patient Signature _____ Date: _____