



NEW PATIENT FORM

Cosmetic and General Dentistry
Sedation Available

212 Cromwell Avenue
Staten Island, New York 10305
718-667-7100

2291 Victory Blvd
Staten Island, New York 10314
718-370-1200

Patient Name: _____ **Date of Birth:** _____

Name of Parent or Guardian, if under 18: _____

Address: _____

Medical History:

General Health: Excellent Good Fair Poor

Physician: _____ Tel. No.: _____

Address: _____

Last Complete Physical: _____ Are you under a Physician's care? _____

If yes, explain: _____

Have you ever been hospitalized? _____ Why? _____

Have you ever had Surgery? _____ Why? _____

Do you have any type of artificial joint (as in hip)? _____

Have you ever been diagnosed as having AIDS or its complex? _____

List all medications to which you are allergic: _____

Do you have any other allergies? _____ If yes, explain: _____

List all medications you have taken within the past week: _____

List all non- prescription medication you are taking, including Aspirin: _____

Have you ever been treated for any of the following:

- | | | | |
|--|---|---|------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Congenital Heart Lesions | | |

Have you ever been diagnosed or treated for any other medical condition not listed above? _____

If yes, explain: _____

Have you ever received Cobalt or radiation therapy? _____

Are you subject to prolonged bleeding? _____ Are you subject to fainting spells? _____

Do you have excessive urination or thirst? _____ Are you pregnant? _____

Have you had any unusual reactions to dental injections or dental treatment? _____

If yes, explain: _____

Patient or Parent Signature: _____ **Date:** _____

Thank you for your cooperation.