SCARSDALE DENTAL GROUP, P.C.
14 HARWOOD COURT, SUITE 211, SCARSDALE, NEW YORK 10583 (914) 723-4707

CONFIDENTIAL PATIENT INFORMATION

Please complete the following medical history so that we will be able to treat you safely and effectively. All information is strictly confidential. Thank you.

PATIENT INFORMATION				
Name	Social Security #			
Address				
Home phone # ()	Work/Cell #			
Birthdate Sex: D Male D Female F	Referred by			
Who will be responsible for this account? \square Self \square Other N	Vame			
Emergency contact name	Phone #			
Are you required to premedicate with an antibiotic prior to de	ental treatment?			
If Yes, medication name				
Pharmacy				
Name of Physician	Physician phone #			
Date of last visit Purpose for visit	Thysician phone #			
Medications: Please include prescriptions, non-prescriptions, Note: The combination of certain illicit drugs and those drugs could be fatal.	s used in dentistry may be dangerous to your health and			
Allergies: Please list all allergies, especially those to medica	ations and latex.			
Have you been hospitalized recently? Yes No Reason				
Do you have or previously had any of the following? Please cho				
☐ Yes ☐ No Abnormal bleeding from a cut or wound	☐ Yes ☐ No Heart attack, heart disease			
☐ Yes ☐ No Acid reflux, ulcers, GI disorders	☐ Yes ☐ No Heart murmur			
☐ Yes ☐ No AIDS or HIV	☐ Yes ☐ No Hepatitis, type			
☐ Yes ☐ No Anemia or blood disorders	☐ Yes ☐ No Herpes			
☐ Yes ☐ No Angina pectoris	☐ Yes ☐ No High blood pressure			
☐ Yes ☐ No Arthritis or rheumatism	☐ Yes ☐ No Injuries to head or neck			
☐ Yes ☐ No Artificial heart valves	☐ Yes ☐ No Kidney disease or renal dialysis			
☐ Yes ☐ No Asthma or pulmonary disease	☐ Yes ☐ No Major illness or operation			
☐ Yes ☐ No Blood transfusion: When?	☐ Yes ☐ No Pacemaker			
☐ Yes ☐ No Cancer, tumor	☐ Yes ☐ No Prosthetic joint replacement			
Yes I No Radiation or chemotherapy	☐ Yes ☐ No Rheumatic fever			
☐ Yes ☐ No Diabetes, týpe	☐ Yes ☐ No Stroke or TIAs			
☐ Yes ☐ No Disabilities: Describe	☐ Yes ☐ No Thyroid problem			
☐ Yes ☐ No Emphysema or respiratory illness	☐ Yes ☐ No Tuberculosis			
☐ Yes ☐ No Endocarditis	☐ Yes ☐ No Unexplained weight loss			
☐ Yes ☐ No Epilepsy or seizures	☐ Yes ☐ No Valvular (mitral) prolapse			
☐ Yes ☐ No Fainting or dizziness	☐ Yes ☐ No Venereal disease			
	Please turn over			

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Page	2

Women only: Do you take oral contraceptives? Yes No Are you pregnant? Yes No Due date Hormone replacement therapy Yes No Due date Hormone replacement therapy Yes No Note: Some medications used in routine dental care may decrease the effectiveness of oral contraceptives. Detaylar History Reason for today's visit Previous dentist's name Date of last dental x-rays	Is there any condition that you have that is not listed on the	e previous page? Ple	ase describe.	-
Are you pregnant? Yes No Due date Hormone replacement therapy Yes No Note: Some medications used in routine dental care may decrease the effectiveness of oral contraceptives. Dental History				
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Reason for today's visit Previous dentist's name Date of last dental x-rays Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you have or had any of the following: Please check yes or no to indicate if you had any or indicate or not indentify yes or no built indicate indicate or not indentify yes or no to indicate if you had any or indicate or not indentify yes or no to indicate if you had any or indicate or not indentify yes or no to indicate if you had any or indicate or not indentify yes or no tiredness Please check yes or no to indicate if yes or no had any or indicate or not indentify yes or no had any or indicate or not indentify yes or no had any or indicate or not indicate indica	DENTAL HISTORY			
Date of last dental visit	Reason for today's visit	•	•••	
Date of last dental x-rays Date of last dental x-rays	Previous dentist's name			·
Please check yes or no to indicate if you have or had any of the following: Yes No Bad breath Yes No Jaw pain or tiredness Yes No Daw pain or tiredness Daw pain or tiredness Yes No Daw pain or tiredness Daw pain or tiredness Yes No Daw pain or tiredness Daw pain or tiredness Yes No Daw pain or tiredness Daw pain or tirednes	Date of last dental visit	Date of last dental	V_f'3\/c	
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