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: ☐ Male ☐ Female Referred by ______________

Who will be responsible for this account? ☐ Self ☐ Other Name ______________

Emergency contact name ______________________ Phone #______________

Are you required to premedicate with an antibiotic prior to dental treatment? ☐ *Yes* ☐ *No*

If Yes, medication name ______________________ *Reason* ______________

Pharmacy ______________________ *Pharmacy phone #* ______________

Name of Physician ______________________ Physician phone # ______________

Date of last visit ____________ Purpose for visit ______________

Medications: Please include prescriptions, non-prescriptions, herbs, homeopathic remedies and other supplements.
Note: The combination of certain illicit drugs and those drugs used in dentistry may be dangerous to your health and could be fatal.

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Allergies: Please list all allergies, especially those to medications and latex. ______________

____

Have you been hospitalized recently? ☐ Yes ☐ No Reason ______________

Do you have or previously had any of the following? *Please check either yes or no.*

☐ Yes ☐ No Abnormal bleeding from a cut or wound
☐ Yes ☐ No Acid reflux, ulcers, GI disorders
☐ Yes ☐ No AIDS or HIV
☐ Yes ☐ No Anemia or blood disorders
☐ Yes ☐ No Angina pectoris
☐ Yes ☐ No Arthritis or rheumatism
☐ Yes ☐ No Artificial heart valves
☐ Yes ☐ No Asthma or pulmonary disease
☐ Yes ☐ No Blood transfusion: When? ____________
☐ Yes ☐ No Cancer, tumor
☐ Yes ☐ No Radiation or chemotherapy
☐ Yes ☐ No Diabetes, type____________
☐ Yes ☐ No Disabilities: Describe____________
☐ Yes ☐ No Emphysema or respiratory illness
☐ Yes ☐ No Endocarditis
☐ Yes ☐ No Epilepsy or seizures
☐ Yes ☐ No Fainting or dizziness
☐ Yes ☐ No Heart attack, heart disease
☐ Yes ☐ No Heart murmur
☐ Yes ☐ No Hepatitis, type ________
☐ Yes ☐ No Herpes
☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Injuries to head or neck
☐ Yes ☐ No Kidney disease or renal dialysis
☐ Yes ☐ No Major illness or operation
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Prosthetic joint replacement
☐ Yes ☐ No Rheumatic fever
☐ Yes ☐ No Stroke or TIAs
☐ Yes ☐ No Thyroid problem
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Unexplained weight loss
☐ Yes ☐ No Valvular (mitral) prolapse
☐ Yes ☐ No Venereal disease

(Please turn over)

Do you have osteoporosis? ❑ Yes ❑ No Do you take bisphosphonates (eg: Actonel, Aredia, Fosamax, Zometa?) ❑ Yes ❑ No Name of medication ______________________________

Is there any condition that you have that is not listed on the previous page? Please describe.

____

Women only: Do you take oral contraceptives? ❑ Yes ❑ No
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

Reason for today's visit ______________________________
Previous dentist's name ______________________________
Date of last dental visit ______________ Date of last dental x-rays ______________

Please check yes or no to indicate if you have or had any of the following:

❑ Yes ❑ No Bad breath
❑ Yes ❑ No Bleeding gums
❑ Yes ❑ No Blisters on lips or mouth
❑ Yes ❑ No Burning sensation on tongue
❑ Yes ❑ No Canker sores
❑ Yes ❑ No Clicking or popping jaw
❑ Yes ❑ No Dry mouth
❑ Yes ❑ No Fingernail biting
❑ Yes ❑ No Food collection between teeth
❑ Yes ❑ No Gagging
❑ Yes ❑ No Grinding or clenching
❑ Yes ❑ No Gums swollen or tender

❑ Yes ❑ No Headaches
❑ Yes ❑ No Jaw pain or tiredness
❑ Yes ❑ No Lip or cheek biting
❑ Yes ❑ No Loose teeth
❑ Yes ❑ No Numbness in mouth or face
❑ Yes ❑ No Oral habits
❑ Yes ❑ No Oral surgery
❑ Yes ❑ No Orthodontic treatment
❑ Yes ❑ No Pain around the ear
❑ Yes ❑ No Periodontal treatment
❑ Yes ❑ No Sores or growths in your mouth

Are your teeth sensitive? ❑ Yes ❑ No Please circle symptom(s): cold, heat, sweets, biting, other ______________.

To the best of my knowledge, I have answered the above questions accurately. I grant the right to the dentist to release health information obtained by me and information about my dental treatment to third party payers and/ or health practitioners.

Signature of Patient ______________________________ **Date** ______________