NORTH BELLMORE DENTAL ASSOCIATES, P.C.

PATIENT INTRODUCTION

TODAY'S DATE:_____

NAME:_____ _____ _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____ SEX:_____ MARITAL STATUS:_____

HOME ADDRESS:_____
HOUSE # & STREET CITY OR TOWN STATE ZIP

HOME PHONE:_____ CELL PHONE:_____
AREA CODE & # AREA CODE & #

E-MAIL ADDRESS _____

OCCUPATION:_____ BUSINESS PHONE:_____

EMPLOYER:_____ SOC. SEC. #_____

IS SOMEONE ELSE RESPONSIBLE FOR PAYMENT? YES _____ NO _____
IF YES, PLEASE FILL IN THE FOLLOWING:

NAME:_____ _____ _____
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT:_____

HOME ADDRESS:_____
HOUSE # & STREET CITY OR TOWN STATE ZIP

HOME PHONE:_____ CELL PHONE:_____
AREA CODE & # AREA CODE & #

OCCUPATION:_____ BUSINESS PHONE:_____

EMPLOYER:_____ SOC. SEC. #_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

NORTH BELLMORE DENTAL ASSOCIATES, P.C.
PATIENT HEALTH RECORD

What is the reason for today's visit? _____

Are you happy with your smile? Yes/No. If not, why?_____

When was your last dental visit? _____

Do you feel nervous about treatment? _____

What is the name and address of your medical doctor? _____

Are you currently taking any medication, including aspirin? Y or N Please list: _____

Do you have any allergies: _____ penicillin _____ codeine _____ aspirin _____ other (please list)

_____

Do you have any problems with prolonged or unexpected bleeding? _____

For women only: Are you pregnant? ____ If yes, your due date? ____ Are you taking birth control pills? _____

Please circle all of the following which may apply to you, either now or in the past:

Congestive heart failure	arthritis
Heart attack, infarction	artificial joints
Angina, chest pains	bleeding disorder
Heart murmur/valve replacement	nervous disorder
Rheumatic fever	psychiatric treatment
Congenital heart disorder	epilepsy, seizures
Pacemaker/defibrillator	fainting, dizziness
High blood pressure	alcoholism/drug addiction
Stroke	Diabetes, high blood sugar
Lung disease, emphysema	steroid drugs (cortisone)
Tuberculosis	sinus trouble
Asthma	seasonal allergies
Liver disease, jaundice, hepatitis	HIV, AIDS
Ulcer disease, colitis	cancer
Anemia, low blood count	chemotherapy, radiation therapy
Thyroid disease	Kidney disease
TMJ –temporomandibular joint dysfunction	Dementia - Alzheimer

All of the preceding answers are true and correct, to the best of my knowledge. If I have a change in health, or if my medications change, I will notify the dentist at the next appointment without fail.

_____ _____ _____

(Date) (Signature of patient, parent or guardian) (Signature of dentist)