



Today's Date: _____

Patient Name _____ Male () Female ()
Last First Initial

Preferred Name: _____ Birth Date _____ Age: _____ SS#: _____

Single () Married () Divorced () Separated () Widowed ()

Address _____ City/State/ Zip _____

Home #: _____ Cell #: _____ Work #: _____

Preferred Contact Number: Home/ Cell / Work Employer Company Name: _____
Email _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

REASON FOR YOUR VISIT TODAY

Previous/Present Dentist: _____ Last Visit Date: _____

(Please circle)

Do you have Dental Insurance? Yes No Are you the Insured? Yes No

Insured's Name: _____ Insured's Birth date: _____

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Insured's SS # or ID#: _____ Insured's Employer: _____

Group #: _____

Do you have secondary Dental Insurance: Yes No

Insured's Name: _____ Insured's Birth date: _____

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Insured's SS # or ID#: _____ Insured's Employer: _____

Group #: _____

*We gladly process your insurance claims on your behalf. Please note that your insurance policy is a contract between you and your insurance carrier. **We are an out of network PPO provider.***

In the event of an emergency, Please provide a contact: Name _____ Phone #: _____

Relation: _____

DENTAL HISTORY

Check (✓) if you have had a problem with any of the following:

- | | | | |
|--|------------------------------------|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | | |
|--------------------------|--|---|--|--|
| <input type="checkbox"/> | <input type="checkbox"/> AIDS | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hernia Repairs | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> | <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet / Ankles |
| <input type="checkbox"/> | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problem | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Other: _____ |

Have you ever taken any of these medications? And, WHEN? _____

- | | | | | | | |
|--------------------------|--|-----------|-----------------------------------|--------------------------------|---------|---------|
| Diet Medications: | <input type="checkbox"/> Dexfenfluramine | Fen-phen | <input type="checkbox"/> Pondimin | <input type="checkbox"/> Redux | | |
| Blood Thinners: | <input type="checkbox"/> Coumadin | Warfarin | BISPHOSPHONATE: | | BONIVA | FOSMAX |
| Other: | <input type="checkbox"/> Levoxyl | Synthroid | | | RECLAST | ACTONEL |

Do you require antibiotics before dental treatment? Yes No

MEDICATIONS

List medications you are currently taking _____

ALLERGIES

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other _____ |

Pharmacy Name _____ Phone _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

X

Signature of Patient, Parent, Guardian or Personal Representative

X

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Patient Name: _____

Today's Date : _____

Are you wearing a removable denture or partial denture? YES NO

If so, how long have you been wearing it or them? _____

Please circle the letter of the response that is closest to yours:

My mouth is: A. Very comfortable
B. Moderately comfortable
C. Uncomfortable

I: A. Follow the dentist's recommendations
B. Sometimes follow recommendations
C. Rarely go and don't care about dentistry

I have: A. Set goals for my dental health
B. Never set goals but would like to
C. Never set goals, nor will I

I put dentistry: A. High on my priority list
B. Low on my priority list
C. On my list but hard to find

I: A. Will do anything to keep my teeth
B. Want to keep my teeth but have a limited budget
C. Believe losing my teeth is part of aging

I am A. Very satisfied with the appearance of my mouth
B. Somewhat satisfied with the appearance of my mouth
C. Dissatisfied with the appearance of my mouth

My present state of dental health is:

- A. Excellent
- B. Good
- C. Poor

Thank you for filling out these forms completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

We want our office to have a friendly and personable atmosphere. We will work together as a team to offer our patients the latest techniques in dentistry. Our office constantly takes continuing education courses which enable us to perform dentistry which exceeds the standard of care today.

We have committed ourselves to the total well being of our patients. We will be compassionate and understanding of their dental concerns. We value each and every person in our practice. We strive for constant improvement and excellence. We strive to develop confidence and a feeling of accomplishment with our patients..

The Krinsky Team