GENERAL DENTISTRY FOR CHILDREN AND YOUNG ADULTS

One Hillcrest Center Drive, Suite 107 • Spring Valley, NY 10977
Kindersmilesdental.com • 845.517.5700

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____
Home address: _____ City: _____ State:_____ Zip:_____
Home phone: _____ Cell: _____ E-mail: _____
SS #: _____ Employer/Occupation: _____
Bus. Phone: _____
Spouse's name & phone #: _____)_____
Emergency name & phone # (other than spouse): _____
Primary dental insurance: _____ Group #:_____
Secondary dental insurance: _____ Group #_____
Subscriber's name: _____ Date of birth # _____
Subscriber ID #_____Subscriber SS #: _____
Name of your medical doctor: _____
Date of last visit to medical doctor: _____
Name of previous dentist: _____
Date of last visit to dentist: _____
Referred to us by: _____

MEDICAL HEALTH HISTORY

Have you ever had any of the following? (Check Boxes that apply):

☐**Yes** ☐**No** Allergies to Anesthetics
☐**Yes** ☐**No** Allergies to Medicine or Drugs
☐**Yes** ☐**No** Arthritis
☐**Yes** ☐**No** Artificial Heart Valves or Joints
☐**Yes** ☐**No** Back Problems
☐**Yes** ☐**No** Blood Disease
☐**Yes** ☐**No** Cancer
☐**Yes** ☐**No** Chemical Dependency
☐**Yes** ☐**No** Chronic Diarrhea
☐**Yes** ☐**No** Circulatory Problems
☐**Yes** ☐**No** Diabetes
☐**Yes** ☐**No** Epilepsy
☐**Yes** ☐**No** Fainting
☐**Yes** ☐**No** Other _____
☐**Yes** ☐**No** General Allergies
☐**Yes** ☐**No** Heart Problems
☐**Yes** ☐**No** Hemophilia
☐**Yes** ☐**No** Hepatitis or Jaundice
☐**Yes** ☐**No** High Blood Pressure
☐**Yes** ☐**No** Kidney Disease
☐**Yes** ☐**No** Liver Disease
☐**Yes** ☐**No** Low Blood Pressure
☐**Yes** ☐**No** Lyme Diseases
☐**Yes** ☐**No** Nervous Problems
☐**Yes** ☐**No** Osteoporosis or Osteopenia
☐**Yes** ☐**No** Psychiatric Care
☐**Yes** ☐**No** RadiationTreatment
☐**Yes** ☐**No** Other _____
☐**Yes** ☐**No** Recent Weight Loss
☐**Yes** ☐**No** Respiratory Disease
☐**Yes** ☐**No** Rheumatic Fever
☐**Yes** ☐**No** Sinus Problems
☐**Yes** ☐**No** Special Diet
☐**Yes** ☐**No** Stroke
☐**Yes** ☐**No** Swollen Neck Glands
☐**Yes** ☐**No** Thyroid Problems
☐**Yes** ☐**No** Tuberculosis
☐**Yes** ☐**No** Ulcer

□**Yes** □**No** Venereal Disease □**Yes** □**No** "AIDS" or other Immunosuppressive Disorders □**Yes** □**No** Other _____

Over please

Are you allergic, or have you reacted adversely, to any of the following?

Local anesthetics ("Novocaine") □Yes □No Penicillin or other antibiotics □Yes □No
Sulfa drugs □Yes □No Aspirin, Acetaminophen, or Ibuprofen □Yes □No
Latex or rubber dam □Yes □No Other _____

Have you ever responded adversely to medical or dental treatments? □Yes □No
_____
Are you taking medication at this time, including Aspirin? □Yes □No if yes, what? _____
For what conditions?_____
Have you taken Bisphosphonate Medications (EX: Fosamax, Boniva) for Osteoporosis? □Yes □No

Do you consume alcohol? □Yes □No if yes, how many drinks per week? _____
Do you smoke? □Yes □No if yes, how much per day? _____
If patient is a child, what is his/her weight? _____
(Women) Do you suspect that you are pregnant? □Yes □No Are you nursing? □Yes □No

Is there anything else we should know about you medical history? □Yes □No
_____

Oral Hygiene History

Last Dental Visit_____ Were radiographs (xrays) taken at that visit? □Yes □No

When was your last full mouth set of radiographs (xrays) taken?_____

Do you have any pain in your teeth? □Yes □No
Sensitivity to cold? □Yes □No
Sensitivity to hot? □Yes □No
Sensitivity to chewing? □Yes □No
Sensitivity to sweets? □Yes □No

Do you feel nervous about having dental treatment? YES NO
If so, what is your biggest concern?_____
Have you ever had an upsetting dental experience? YES NO
If so, please describe _____
Any specific areas or teeth you would like us to evaluate? YES NO
If so, where?_____

Does (or did) your child use a bottle in bed? □Yes □No If yes for how long?_____
How often does your child brush?_____Floss?_____
Do you help your child brush? □Yes □No

The above mentioned information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Parent Signature: _____ Date_____

Provider Signature_____ Date _____