Hyde Park Family Dental
24 Main Street
Hyde Park, NY 12538
Ph # : 845-229-7070

Patient Personal Information

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				Emergency Contact		Emergency Phone #	
Email				Student		SSN	
Health Care Guardian Name				School Name			
Health Care Guardian Phone #				Referral Type			

Patient Medical Information

Allergic To

- ☐ Y ☐ N No Known Allergies
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Tetracycline
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Metals
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N No Epinephrine

Check, if applicable

- ☐ Y ☐ N No Change Since Last Recorded
- ☐ Y ☐ N No Known Concerns or Issues
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Artifical Heart Valve
- ☐ Y ☐ N Pacemaker
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N High Cholesterol
- ☐ Y ☐ N Bruise Easily
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Cold Sores
- ☐ Y ☐ N Lyme Disease
- ☐ Y ☐ N Respiratory Disease
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Allergies
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Diabetes Type 1
- ☐ Y ☐ N Diabetes Type 2
- ☐ Y ☐ N Blood Disease/Disorder
- ☐ Y ☐ N HIV/AIDS
- ☐ Y ☐ N Herpes Lesions
- ☐ Y ☐ N Ulcers
- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Cortisone Treatment
- ☐ Y ☐ N Mirgraines
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Growths/ Tumors
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Kidney Disease
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Menopause
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Parkinsons
- ☐ Y ☐ N Excessive Bleeding
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Chest Pain
- ☐ Y ☐ N Dizziness/ Fainting
- ☐ Y ☐ N Epilepsy/Seizures
- ☐ Y ☐ N Mental Disorders
- ☐ Y ☐ N Nervous Disorders/ Anxiety
- ☐ Y ☐ N Eating Disorders
- ☐ Y ☐ N Drug/Alcohol Addiction
- ☐ Y ☐ N Head Injuries
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Acid Reflux/GERD
- ☐ Y ☐ N Hepatitis A
- ☐ Y ☐ N Hepatitis B
- ☐ Y ☐ N Hepatitis C
- ☐ Y ☐ N HPV Virus
- ☐ Y ☐ N Sleep Apnea
- ☐ Y ☐ N Cancer
- ☐ Y ☐ N PRE-MED
- ☐ Y ☐ N Blood Thinners

- Joint Replacement

Other

- ☐ Y ☐ N Scanned Paper Charts
- ☐ Y ☐ N See Scanned Documents: Pt Note
- ☐ Y ☐ N See Medical History

Medical Questionnaire

Medical Questionnaire

Family Physician _____

Phone _____

Are you currently under care of a Physician ? _____

If Yes, what is the condition being treated ?

Have you had any serious illness, operation or been hospitalized within the past 5 years ?

If Yes, what illness or problem ?

Are you currently taking any medication ?

If Yes, what ?

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)

Do you use alcoholic beverages ?

Do you smoke ?

Women Only

Are you pregnant?

If Yes, what is your due date ?

Are you currently nursing ?

Do you have menstrual period problems ?

Are you on hormone replacement therapy ?

Are you on birth control pills / fertility drugs ?

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**