

Hvde Park Familv 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	

Person responsible/guarantor for paying bills

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		SSN	
Email			

Do you have Primary Dental Insurance? No Do you have Secondary Dental Insurance? No

<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Group No/Name		Group No/Name	
Insurance Name		Insurance Name	
Phone #		Phone #	
Employer Name		Employer Name	
Subscriber Last, First		Subscriber Last, First	
Subscriber Address		Subscriber Address	
City, State, Zip		City, State, Zip	
Relationship to Patient	Birth Date	Relationship to Patient	Birth Date
Subscriber ID		Subscriber ID	

Patient Medical Information

Allergic To	<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Nervous Disorders/ Anxiety
<input type="checkbox"/> Y <input type="checkbox"/> N No Known Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N Cortisone Treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Eating Disorders
<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N Drug/Alcohol Addiction
<input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline	<input type="checkbox"/> Y <input type="checkbox"/> N High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Head Injuries
<input type="checkbox"/> Y <input type="checkbox"/> N Sulfa Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N Bruise Easily	<input type="checkbox"/> Y <input type="checkbox"/> N Growths/ Tumors	<input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches
<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Acid Reflux/GERD
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Cold Sores	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis A
<input type="checkbox"/> Y <input type="checkbox"/> N Latex Rubber	<input type="checkbox"/> Y <input type="checkbox"/> N Lyme Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis B
<input type="checkbox"/> Y <input type="checkbox"/> N Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis C
<input type="checkbox"/> Y <input type="checkbox"/> N Local Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N HPV Virus
<input type="checkbox"/> Y <input type="checkbox"/> N No Epinephrine	<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Menopause	<input type="checkbox"/> Y <input type="checkbox"/> N Sleep Apnea
Check, if applicable	<input type="checkbox"/> Y <input type="checkbox"/> N Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer
<input type="checkbox"/> Y <input type="checkbox"/> N No Change Since Last	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Parkinsons	

<input type="checkbox"/> Y <input type="checkbox"/> N Recorded	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes Type 1	<input type="checkbox"/> Y <input type="checkbox"/> N Excessive Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N PRE-MED
<input type="checkbox"/> Y <input type="checkbox"/> N No Known Concerns or Issues	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes Type 2	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Thinners
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Disease/Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain	- Joint Replacement
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N HIV/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N Dizziness/ Fainting	Other
<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes Lesions	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Scanned Paper Charts
<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N Mental Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N See Scanned Documents: Pt Note
<input type="checkbox"/> Y <input type="checkbox"/> N Stroke			<input type="checkbox"/> Y <input type="checkbox"/> 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