PARK AVENUE DENTAL COSMETICS

35 East 35th St. | New York, NY 10016 | Tel: (212) 532-0690
www.parkavenuedentistnyc.com

Patient Health Record

The following information is requested to assist Park Avenue Dental Cosmetics, LLC in administering the proper dental service. Please answer the questions to the best of your ability, and use the additional space for answers requiring clarification or any additional information. Thank you for your cooperation.

PATIENT INFORMATION

Name: (Last)_____ (First) _____ (MI)_____
Home Address: (Street)_____(Apt)_____
(City/Town)_____(State)_____(Zip)_____
Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____
E-Mail Address _____
Business Address _____
Business Phone (_____) _____ - _____ Occupation: _____
Date of Birth (mm/dd/yyyy): ____ /____ /_____ Sex: Male □ Female □ Height: _____ Weight: _____
Marital Status: Single □ Married □ Widowed □ Divorced □ Spouse's Name: _____
Type of Dental Insurance (if applicable) _____
Social Security Number (for insurance purposes only): _____ - _____ - _____
Referred by: (Name) _____
Reason for your visit: _____
Emergency Contact: (Name)_____
(Address)_____ Phone (_____) _____ - _____

MEDICAL HEALTH

Current Physician: (Name) _____
(Address)_____
General Health: Excellent □ Good □ Fair □ Poor □ Last Complete Physical?:_____
Are you presently under the care of a physician?: Yes □ No □
If Yes, for what reason?: _____
Are you taking medications now?: Yes □ No □
If Yes, please list all medications: _____
Are you allergic to: Antibiotics □ Codeine □ Aspirin □ Local Anesthetics □
Any other medications?: _____
Have you ever been hospitalized? If so, give name of hospital, reason and dates:

_____

_____

PARK AVENUE DENTAL COSMETICS

35 East 35th St. | New York, NY 10016 | Tel: (212) 532-0690
www.parkavenuedentistnyc.com

Patient Health Record

Please answer the following:

Yes □ No □ Have you had an radiological diagnostic x-rays in the last five years?
Yes □ No □ Have you had any blood transfusions?
Yes □ No □ Are you currently trying to modify your weight?
Yes □ No □ Do you take any medications to help in weight reduction?
Yes □ No □ Do you smoke cigarettes? How many per day? _____
Yes □ No □ Do you consume alcohol on a daily basis?
Yes □ No □ Have you experienced any recent weight change?
Is your blood pressure: Normal □ High □ Low □

Women Only:

Yes □ No □ Are you pregnant? How long? _____
Yes □ No □ Do you experience pre-menstrual syndrome?

Do you have/have you ever had any of the following?:

Yes □ No □ Chest Pains
Yes □ No □ Heart Disease
Yes □ No □ Rheumatic Fever
Yes □ No □ Congenital Heart Defects
Yes □ No □ Heart Murmur
Yes □ No □ Postural Hypotension (fainting spells)
Yes □ No □ Hypertension
Yes □ No □ Kidney Problems
Yes □ No □ Stroke
Yes □ No □ Thyroid Problems
Yes □ No □ Hormonal Problems
Yes □ No □ Ulcers
Yes □ No □ Tuberculosis or Lung Disease
Yes □ No □ Diabetes
Yes □ No □ Epilepsy or Seizures
Yes □ No □ Anemia
Yes □ No □ Sickle Cell Disease
Yes □ No □ Cancer of Leukemia
Yes □ No □ Psychiatric Problems
Yes □ No □ Glaucoma
Yes □ No □ Prosthetic Valves or Joints

Yes □ No □ Jaundice
Yes □ No □ Bruise Easily
Yes □ No □ Prolonged Bleeding Problems
Yes □ No □ Asthma or Hay Fever
Yes □ No □ Allergies or Hives
Yes □ No □ Sinus Trouble
Yes □ No □ Arthritis
Yes □ No □ Excessive Urination and/or Thirst
Yes □ No □ Sexually transmitted diseases: (Gonorrhea, Syphilis, Genital Herpes)
Yes □ No □ Genetic Problems
Yes □ No □ Skin Disease
Yes □ No □ AIDS/HIV Positive
Yes □ No □ Unexplained Fevers
Yes □ No □ Persistent Cough
Yes □ No □ Prolonged Sore Throat
Yes □ No □ Enlarged Lymph Nodes
Yes □ No □ Night Sweats
Yes □ No □ Persistent Diarrhea
Yes □ No □ Bluish-Reddish Lesions
Yes □ No □ Fatigue

Yes □ No □ Have you ever been tested for Hepatitis?
Yes □ No □ Do you have a history of cold sores, fever blisters, or canker sores?
Yes □ No □ Are you being treated with immunosuppressive drugs?
Yes □ No □ Have you ever used drugs for recreation purposes?

PARK AVENUE
DENTAL COSMETICS

35 East 35th St. | New York, NY 10016 | Tel: (212) 532-0690
www.parkavenuedentistnyc.com

Patient Health Record

DENTAL HEALTH

When was your last dental visit? _____

Have you ever had any serious problems associated with previous dental treatment? Yes □ No □

If yes, explain: _____

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

What texture brush do you use? Soft □ Medium □ Hard □

Yes □ No □ Do you routinely use a mouth rinse? How often? _____

Yes □ No □ Do you experience dry mouth (Xerostomia)?

Yes □ No □ Do your gums feel tender or swollen?

Yes □ No □ Do your gums bleed while brushing and/or flossing?

Yes □ No □ Do you avoid brushing any part of your mouth because of pain or sensitivity?

Yes □ No □ Do you feel twinges of pain when your teeth come in contact with hot, cold, sweet or sour?

Yes □ No □ Are any of your teeth sensitive to air or during chewing?

Yes □ No □ Do you chew on only one side of your mouth?

Yes □ No □ Does food catch between your teeth?

Yes □ No □ Do you feel your teeth are affecting your health in any way?

Yes □ No □ Have you ever had professional advice in dental home care?

Yes □ No □ Do you clench or grind your teeth while sleeping or during the day?

Yes □ No □ Do your facial muscles ever feel tired?

Yes □ No □ Do you wear full dentures? Upper □ Lower □

Yes □ No □ Do you wear partial dentures? Upper □ Lower □

Yes □ No □ Do you have retention problems with your full or partial dentures?

Yes □ No □ Do you gag easily?

Yes □ No □ Are you apprehensive (nervous) about your dental treatment?

If yes, have you had: Nitrous Oxide □ Medication prior to treatment □

Please add anything you feel is important:

_____

_____

CONSENT

The undersigned hereby authorizes Park Avenue Dental Cosmetics, LLC to perform all necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patients' dental or oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

Patient's Name (please print): _____

Patient or Legal Guardian's Signature: _____ Date: ____/____/_____

Doctor's Signature: _____ Date: ____/____/_____