

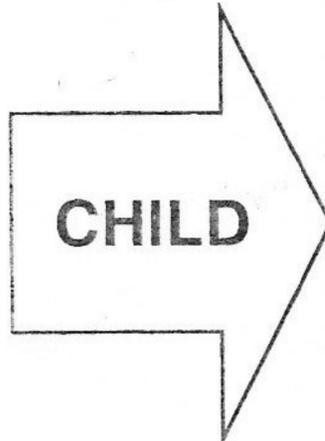
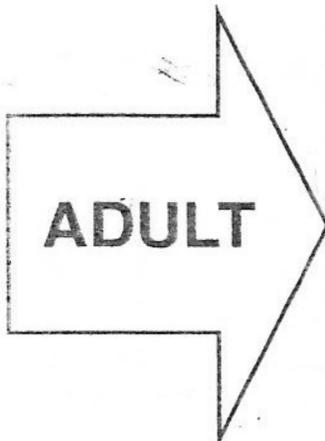
PATIENT HEALTH HISTORY

Please Read

Will you kindly answer the following questions. In this office, we are very much interested in helping you with your program of health and well being. We feel that this interest in your appearance, comfort, and ability to chew, digest and enjoy your food is one of the reasons why you are here.

In order to prevent or control disease to maintain healthy teeth, gums and bone, it is necessary as a part of any complete examination, to know about your general health and feelings. This information is invaluable in determining accurate treatment suggestions, which will be discussed with you in detail. This information, of course, will be held confidential.

Referred To Office By _____



PLEASE PRINT		1
Name	_____	
Address	_____	
City	_____ State _____ Zip _____	
Home Phone #	_____	
Cell #	_____	
E-mail	_____	
Business Address	_____	
City	_____ State _____ Zip _____	
Bus. Phone #	_____ Birthdate _____	
Married _____ Single _____ Divorced _____ Widowed _____		
Occupation	_____	
SS#	_____	
Name	_____	
Address	_____	
City	_____ State _____ Zip _____	
Home Phone #	_____	
Birthdate	_____ Age _____ Grade _____	
School	_____	
* If your child's name and address are not the same as yours, please fill in the box on top also.		

INSURANCE	2
Primary Carrier	
Insurance Co.	_____
Ins. Tel #	_____
Employer	_____
Union or Local #	_____
Group #	_____
SS #	_____
Primary Ins. Name	_____
Primary Ins. D.O.B.	_____
Secondary Carrier	
Insurance Co.	_____
Ins. Tel #	_____
Employer	_____
Union or Local #	_____
Group #	_____
SS #	_____
Sec. Ins. Name	_____
Sec. Ins. D.O.B.	_____

JAY PISKIN, D.D.S.

83 COVERT AVENUE
FLORAL PARK, N.Y. 11001
(516) 354-1213

MEDICAL HISTORY:

1. GENERAL HEALTH (please check): EXCELLENT GOOD FAIR POOR

2. NAME AND ADDRESS OF PHYSICIAN _____

(PHONE #) _____

3. LAST COMPLETE PHYSICAL? _____

4. ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? YES NO
IF YES, PLEASE EXPLAIN _____

5. HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE LAST 5 YEARS? YES NO
IF YES, PLEASE EXPLAIN _____

6. ARE YOU TAKING ANY MEDICATION NOW? (PILLS, VITAMINS, SYRUP, ETC.)..... YES NO
PLEASE LIST _____

7. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS OR DISEASES?

(CHECK BOX)	YES	NO		YES	NO
HEART DISEASE OR HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	JAUNDICE, HEPATITIS OR LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA OR HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>
HEART MURMUR OR MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>	SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>
ABNORMAL BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	HIV OR AIDS	<input type="checkbox"/>	<input type="checkbox"/>
ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR SORE JOINTS	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS OR LUNG DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES OR ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART LESIONS	<input type="checkbox"/>	<input type="checkbox"/>	VENEREAL DISEASE (SYPHILIS OR GONORRHEA)	<input type="checkbox"/>	<input type="checkbox"/>
HEART VALVE OR JOINT REPLACEMENT	<input type="checkbox"/>	<input type="checkbox"/>	CANCER, TUMORS OR GROWTHS	<input type="checkbox"/>	<input type="checkbox"/>
OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>			

8. ARE YOU ALLERGIC TO ANY DRUGS OR MEDICATION SUCH AS PENICILLIN, CODEINE, ASPIRIN OR LOCAL INJECTED ANESTHETICS? YES NO
IF YES, WHAT? _____

9. ANY ALLERGIES TO LATEX? YES NO

10. ARE YOU TAKING BLOOD THINNERS OR SUBJECT TO PROLONGED BLEEDING? YES NO

11. DO YOU HAVE EXCESSIVE URINATION AND/OR THIRST? YES NO

12. DO YOU USE TOBACCO? YES NO

WOMEN:

1. ARE YOU PREGNANT? YES NO

DENTAL HISTORY:

1. ARE YOU AWARE OF ANY DENTAL PROBLEMS AT THIS TIME? YES NO
IF YES, PLEASE EXPLAIN _____

2. WHEN WAS YOUR LAST DENTAL VISIT? _____ YES NO

3. ARE YOU SEEN IN A DENTAL OFFICE ON A REGULAR BASIS? YES NO
IF YES, PLEASE EXPLAIN _____

4. WHEN WAS YOUR LAST FULL MOUTH SERIES OF X-RAYS TAKEN? _____

5. WHEN WAS YOUR LAST DENTAL CLEANING? _____

6. DO YOUR GUMS BLEED WHILE BRUSHING? YES NO

7. DO YOU HAVE A BAD TASTE OR ODOR IN YOUR MOUTH OR BEEN TOLD YOU HAVE BAD BREATH?.. YES NO

8. HOW OFTEN DO YOU BRUSH YOUR TEETH? _____

9. DO YOU USE ANY OF THE FOLLOWING?

TOOTHBRUSH HARD MEDIUM SOFT FLOSS TOOTHPICKS OTHER _____

10. DO YOU CHEW ON ONLY ONE SIDE OF YOUR MOUTH? YES NO
IF YES, PLEASE EXPLAIN _____

11. ARE YOU FAMILIAR WITH THE TERM, "PREVENTIVE DENTISTRY"? YES NO

12. ARE YOU PLEASED WITH THE APPEARANCE OF YOUR TEETH? YES NO
IF NOT, WHY? _____

13. DOES THE NOISE OF HIGH SPEED EQUIPMENT BOTHER YOU? YES NO

14. INTERESTS AND HOBBIES _____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PROCEEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM THE DOCTOR OF DENTISTRY AT THE NEXT APPOINTMENT WITHOUT FAIL.

DATE _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____

SIGNATURE OF DENTIST _____