Cortlandt Manor Dental

General and Cosmetic Dentistry
914.737.5700

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Cortlandt Manor Dental
99 Locust Avenue
Cortlandt Manor, NY 10567

Patient Medical/Dental Information Form

Please note that all information on this medical dental form will remain strictly confidential. PLEASE PRINT.

Date_____ Purpose of today's visit? _____

PERSONAL INFORMATION

Patient Name_____ Date of Birth_____ Social Security # _____
First MI Last

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____ Email _____

Do you prefer calls at: ❑ Home ❑ Cell ❑ Work

Are you: ❑ a Minor ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Separated

Name of Spouse (or parent if a minor) _____

You or your parent's employer _____

If you are a student, name of school/college_____ City_____ State _____

Person to contact in case of emergency: Name_____ Relation_____ Phone _____

How did you hear about us? ❑ Internet (which web site)_____ ❑ Yellow Pages ❑ Insurance

❑ Patient (please provide name so we can thank them) _____

INSURANCE INFORMATION

Name of insured_____ Relationship to patient _____

Date of Birth_____ Social Security # _____

Name of Employer _____ Phone _____

Employer Address _____ City_____ State_____ Zip _____

Insurance Company_____ Policy/Group # _____

Is there a secondary insurance ❑ Yes ❑ No

MEDICAL HISTORY INFORMATION

Have you ever had any of the following? Please check all that apply.

❑ Anemia	❑ Excessive Bleeding	❑ Liver Disease	❑ Sinus Problems
❑ Artificial Heart Valves	❑ Fainting	❑ Mitral Valve Prolapse	❑ Skin Rash
❑ Artificial Joints	❑ Glaucoma	❑ Nervous Problems	❑ Stroke
❑ Asthma	❑ Headaches	❑ Osteoporosis	❑ Swelling of Feet, Ankle
❑ Blood Disease	❑ Heart Disease Problems	❑ Pacemaker	❑ Thyroid Problems
❑ Cancer	❑ Heart Murmur	❑ Psychological Disorders	❑ Tonsillitis
❑ Chemical Dependency	❑ Hemophilia	❑ Radiation Therapy	❑ Tuberculosis
❑ Circulatory Problems	❑ Hepatitis A, B, C	❑ Respiratory Problems	❑ Tumors
❑ Diabetes	❑ High Blood Pressure	❑ Rheumatic Fever	❑ Ulcer
❑ Dizziness	❑ HIV/AIDS	❑ Scarlet Fever	❑ Venereal Disease
❑ Epilepsy	❑ Kidney Disease	❑ Shortness of Breath	

Patient Medical/Dental Information Form (page 2)

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Physician Name_____ Phone _____

Have you had any serious illnesses in the last 2 years? ❑ Yes ❑ No

Are you currently taking any medications regularly? ❑ Yes ❑ No

If yes, please list _____

Do you suffer from sleep apnea? ❑ Yes ❑ No

Do you have high blood pressure? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Are you taking birth control pills? ❑ Yes ❑ No

ALLERGY INFORMATION

Do you have any allergies to the following? Please check all that apply.

❑ Aspirin
❑ Codeine
❑ Dental anesthetics
❑ Erythromycin
❑ Jewelry
❑ Latex
❑ Metals
❑ Penicillin
❑ Tetracycline
❑ Other _____

DENTAL HISTORY INFORMATION

How long since your last dental visit? _____

Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely

Have you ever had or require the following for dental treatment?
❑ Gas (Nitrous oxide/laughing gas) ❑ Intravenous sedation ❑ General Anesthesia

Are you required to pre-medicate prior to dental visits? ❑ Yes ❑ No

Are you concerned about or experiencing any of the following dental problems? Please check all that apply.

❑ Ability to eat
❑ Bad breath
❑ Bleeding gums
❑ Clicking/pain in the jaw joints
❑ Crooked teeth
❑ Discolored fillings
❑ Existing crowns, bridges or dentures
❑ Food trapping between your teeth
❑ Gaps between your teeth
❑ Grinding or clenching of your teeth
❑ Head/neck ache
❑ Missing teeth
❑ Previous dental treatment
❑ Roughness of existing fillings
❑ Sensitivity to hot or cold
❑ Sensitivity when eating
❑ Silver fillings
❑ Staining your teeth
❑ Tooth cleaning techniques
❑ Your smile

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated and I will assume responsibility for the fees associated with those procedures.
- I understand that the practice requires a minimum 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee of $50.00 will be incurred if I fail to do so.
- I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures, and publications that the dentist may author.
- I am aware that payment is required on the day of treatment unless other arrangements with the office manager have been previously agreed upon.

_____ _____

Patient/Guardian Signature Today's Date