



NYC SMILE DESIGN

We transform your smile. You transform your life.

Patient Health History

Name _____

- How can we help you? _____
- What is your expectation for today appointment? _____
- What would you like to begin addressing immediately? _____
- How confident do you feel about the appearance of your smile? _____
- Are you pleased with the dentistry you've had up until this point? Y/N Why? _____
- What do you like best about your general dentist? _____
- We want your experience to be perfect, please share with us any negative dental experiences you've encountered _____

- Ever had a dental emergency? Y/N Describe _____
- Ever experience anxiety in the: [Waiting room? Y/N] [Dental chair? Y/N] [When discussing costs? Y/N] [When scheduling? Y/N]
- Dental cleanings frequency?(Please Circle)Every: 3 / 4 / 6 / 12 months or longer?(Please Circle)Determined by: My Dentist/Myself
- My gums bleed when: Brushing? Y/N Flossing? Y/N Randomly? Y/N I've had periodontal treatment - Y/N When: _____
- Unpleasant taste in mouth? Y/N Unpleasant smell in mouth? Y/N (Please Circle)
- I've had orthodontic treatment (braces): Y/N When? _____ What type? _____ For how long? _____
- Have you ever worn: A night guard or occlusal appliance? Y/N - An orthotic? Y/N Do you still wear it? Y/N
- In your own words, how would you describe your dental health? _____

Are you allergic to any of the following:

- [Y] [N] Aspirin [Y] [N] Acetaminophen [Y] [N] Ibuprofen [Y] [N] Codeine [Y] [N] Local Anesthetics
- [Y] [N] Fluoride [Y] [N] Tetracycline [Y] [N] Erythromycin [Y] [N] Latex [Y] [N] Penicillin/Amoxicillin
- [Y] [N] Metals (Gold, stainless steel, _____) [Y] [N] Any other medication? _____
- [Y] [N] Are you required to take pre-medication before dental treatment? If yes, for what condition? _____

Do any of the following conditions apply: Please select where applicable Yes, No, or Sometimes

- [Y] [N] Caffeine consumption within 2-3 hours of bedtime: Daily/Weekly/Occasionally (Please Circle)
- [Y] [N] Sedative before bed? Daily/Weekly/Occasionally (Please Circle)
- [Y] [N] [S] Alcohol consumption? _____ cups per day/week/month (Please Circle)
- [Y] [N] [S] Do you smoke? _____ per: day/week/month (Please Circle)
- [Y] [N] [S] Chewing tobacco? Daily/Weekly/Occasionally (Please Circle)
- [Y] [N] [S] Drug use? Type? _____ frequency _____

- | | | |
|---|--|---------------------------------|
| [Y] [N] (Women) Taking birth control | [Y] [N] Thyroid or parathyroid disease | [Y] [N] Anemia |
| [Y] [N] (Women) Pregnant | [Y] [N] Stomach or Duodenal ulcer | [Y] [N] Emphysema |
| [Y] [N] (Men) Prostate disorders | [Y] [N] HIV/AIDS | [Y] [N] Asthma |
| [Y] [N] Heart problems | [Y] [N] Radiation therapy | [Y] [N] Sinus problems |
| [Y] [N] Heart murmur | [Y] [N] Chemotherapy | [Y] [N] Kidney disease |
| [Y] [N] Epilepsy or convulsions (seizures) | [Y] [N] History of a stroke | [Y] [N] Glaucoma |
| [Y] [N] Often exhausted or fatigued | [Y] [N] Hepatitis (type _____) | [Y] [N] Digestive disorders |
| [Y] [N] Hives, skin rash, hay fever | [Y] [N] Jaundice | [Y] [N] Liver disease |
| [Y] [N] Tumor or abnormal growth | [Y] [N] Rheumatic Fever | [Y] [N] Arthritis |
| [Y] [N] Lumps or swelling in the mouth | [Y] [N] Tuberculosis | [Y] [N] Diabetes |
| [Y] [N] Prolonged bleeding due to slight cut | [Y] [N] Head or neck injuries | [Y] [N] Contact Lenses |
| [Y] [N] Emotional problems | [Y] [N] Antidepressant medications | [Y] [N] Psychiatric treatment |
| [Y] [N] Recent changes in your general health | [Y] [N] Subject to frequent headache | [Y] [N] Often unhappy/depressed |
| [Y] [N] Artificial Prosthesis/ heart valve/joints | [Y] [N] High or Low-blood pressure (Please Circle) | |
| [Y] [N] Negative reaction to local anesthesia? | [Y] [N] Have trouble getting numb before dental treatment? | |

The information indicated above is truthful and accurate to the best of my knowledge.

Signature _____ Date _____



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Today's Date _____

Your Legal Name:(First) _____ (MI) _____ (Last) _____ DOB ____/____/____

What would you like our team to call you? _____

Home Address: _____ Apt# _____ City _____ State _____ Zip _____

Mobile Phone: () _____ Work Phone: () _____ Ext _____ Home Phone: () _____

E-mail Address: _____

Emergency Contact Information:

Name:(First) _____ (MI) _____ (Last) _____ Relationship: _____

Mobile Phone: () _____ Work Phone: () _____ Ext _____ Home Phone: () _____

•Who[is][was]your General dentist? _____ For how long? _____ Most recent: Exam & x-rays? _____

•Date of most recent dental treatment? _____ What kind of treatment? _____

•Name of Physician _____ Most recent physical _____

•Presently being treated for any illness? (Please Circle) [Y][N] If so, please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

•List any medication, herbal supplements, and or vitamins taken within the last two years

•Reason for today's visit: _____

How did you learn about us?

Internet-Name of website? _____ Family member or friend? Name _____

Publication-Name of source? _____ Referring Doctor? Name _____

Is the patient under 18 years of age? If YES please complete this section.

•Responsible party's information for minor patient:

Legal Name:(First) _____ (MI) _____ (Last) _____ DOB ____/____/____

Home Address _____ Apt# _____ City _____ State _____ Zip _____

Mobile Phone: () _____ Work Phone: () _____ Ext _____ Home Phone: () _____

E-mail Address: _____

Consent for use and disclosure of health information

•**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

•**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting our office at (212)452-3344.

Please Select [Self] or [Guardian]

I (PRINT NAME) _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

•I have received NYC Smile Design's notice of privacy practices (Please see attached page)

Signature _____ Today's Date _____