SMILES·NY
COSMETIC AND IMPLANT DENTISTRY

220 EAST 63RD STREET
LOBBY F
NEW YORK, NY 10065

# Health Information

Date:_____

Last Name: _____ First Name:_____ M.I._____

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

- ☐ AIDS
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Tumors
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Epilepsy
- ☐ Ulcers
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Veneral Disease
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Osteoporosis

If yes, please explain: _____

Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No

Name of Physician: _____ Phone: _____

Please list all allergies (for example medications, foods, latex, etc) _____

_____

Please list all medications you are currently taking: _____

Are you pregnant? ☐ Yes ☐ No

Please list any other health issues not listed above that need further clarification: _____

_____

To the best of my knowledge, all of the answers concering my health and dental information provided are true and correct. If I ever have changes in my health, I will inform the doctors at the next appointment without fail. I authorize the doctors & staff of SmilesNY to perform those procedures as deemed necessary or advisable to maintain my dental health.

_____ Date: _____

Signature of patient, parent or guardian