Alan B. Kohn, DDS, PC
Evan J. Kollander, DDS, PLLC
Mordechai M. Eisenberger, DDS
Jeffrey M. Galler, DDS

ALL INFORMATION IS COMPLETELY CONFIDENTIAL

CHART #:

PATIENT INFORMATION

Patient Name: Date:

Last First MI

Date of Birth: Gender:

Phone (Cell): (Home): (Work):

Email Address:

Street Address:

Street Apt #

City State Zip Code

Emergency Contact Name/ Phone Number/ Relationship:

HEALTH INFORMATION

Date of Last Dental Visit: **Reason:**

Have you had/ have any of the following? Please check all that apply

☐ Heart (Attack, Surgery, Disease)	☐ Kidney Disease	☐ Hepatits A
☐ Chest Pain	☐ Ulcers	☐ Hepatits B
☐ Congenital Heart Disease	☐ Diabetes	☐ Hepatits C
☐ Heart Murmur	☐ Thyroid Problems	☐ Veneral Disease
☐ High/ Low Blood Pressure	☐ Glaucoma	☐ AIDS/ HIV Positive
☐ Mitral Valve Prolapse	☐ Contact Lenses	☐ Cold Sores/ Fever Blisters
☐ Artificial Heart Valve/ Pacemaker	☐ Emphysema	☐ Blood Transfusion
☐ Rheumatic Fever	☐ Chronic Cough	☐ Hemophilia
☐ Arthritis/ Rheumatism	☐ Tuberculosis	☐ Sickle Cell Disease
☐ Cortisone Medicine	☐ Asthma	☐ Bruise Easily
☐ Swollen Ankles	☐ Hay Fever/ Allergy/ Hives	☐ Neurological Disorder
☐ Stroke	☐ Radiation Therapy	☐ Epilepsy/ Seizures
☐ Artificial Joints (Hip, Knee)	☐ Chemo Therapy	☐ Fainting or Dizzy Spells
☐ Sinus Trouble	☐ Tumor	☐ Nervous/ Anxious
☐ Latex Sensitivity	☐ Liver Disease/ Jaundice	☐ Psychiatric/ Psychological Care

Have you been admitted to a hospital or needed emergency care during the past 2 years? ☐ Yes ☐ No

If yes, please explain:

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

Name of Physician: **Phone:**

Have you ever been instructed to take ANY medication or ANY precaution prior to having dental treatment? ☐ Yes ☐ No

If yes, please explain:

Are you currently taking ANY medications? ☐ Yes ☐ No

If yes, please list ALL:

Are you allergic to ANY medications or substances? ☐ Yes ☐ No

If yes, please list ALL:

I understand the above information in necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature: **Date:**

Submit