WASHINGTON SQUARE DENTAL GROUP, P.C.

MARK D. HOROWITZ, D.D.S. ● KORI L. DARLING, D.D.S. ● ANNE X. TRUONG, D.D.S.

TWO FIFTH AVENUE, SUITE 4 – NEW YORK, N.Y. 10011

TEL: 212-674-4011 - EMAIL: WASHINGTONSQUAREDENTALGROUPNYC@GMAIL.COM

PATIENT INFORMATION

Patient Name: _____ Gender: _____ Date: _____

Date of Birth: _____ SSN: _____

Check One: _____ Married _____ Single _____ Divorced _____ Widowed

Address: _____

Street Apt. #

_____

City State Zip

REFERRAL INFORMATION / HOW DID YOU HEAR ABOUT OUR PRACTICE?

Friend/Family Members Name: _____ or,

____ Google ____ Internet ____ Yelp ____ Walk-In ____ Live/Work in Neighborhood

____ Referred by Dr. _____

CONTACT INFORMATION

Cell: _____ Home: _____ Work: _____ Ext: _____

Email: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

EMPLOYMENT INFORMATION

Employer Name: _____ Occupation: _____

Employer Address: _____ Phone Number: _____

INSURANCE INFORMATION

Dental Insurance: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Address: _____

Subscriber SSN: _____ Relationship to Patient: _____

ID Number: _____ Group Number: _____

PLEASE PRINT NAME: _____

GENERAL HEALTH HISTORY

Name of General Physician: _____ Tel: _____
Date of Last Physical Exam: _____ Allergies: _____
Daily Medications/Dosages: _____
Name of Pharmacy: _____ Pharmacy Phone Number: _____
Pharmacy Address: _____
Recent Surgeries/Joint Replacement History: _____

PLEASE CHECK ANY THAT APPLY

- ☐ Anemia
- ☐ Heart Condition
- ☐ Pacemaker
- ☐ Thyroid
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Diabetes
- ☐ Liver Problems
- ☐ Kidney Failure
- ☐ Fainting Spells
- ☐ Anxiety / Mental Illness
- ☐ Gallbladder
- ☐ Cancer History
- ☐ Chemo/Radiation
- ☐ Bleeding Issues
- ☐ Blood Disease
- ☐ Blood Transfusions
- ☐ Asthma
- ☐ Mitral Valve Prolapse
- ☐ AIDS/HIV
- ☐ Jaw Pain
- ☐ Rheumatic Fever
- ☐ Artificial Heart Valve
- ☐ Glaucoma
- ☐ Stroke History
- ☐ Tobacco (Smoker)
- ☐ Circulatory Problems
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Epilepsy
- ☐ Headaches / Migraine

DENTAL HISTORY

Previous Dentist: _____ Phone: _____
Address: _____
Most Recent Exam: _____ Cleanings: _____ X-Rays: _____
What are your immediate dental concerns? _____
Are you happy with the appearance of your smile? Circle One: Yes / No
Would you like to discuss enhancing the appearance of your smile? Circle One: Yes / No
Would you like to discuss options for teeth whitening? Circle One: Yes / No
Have you undergone prior orthodontic treatment? Circle One: Yes / No
Check if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking/Popping Jaw
- ☐ Food Collection
- ☐ Grinding Teeth
- ☐ Loose Teeth
- ☐ Broken Fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity to Hot/Cold/Sweets
- ☐ Mouth Sores/Growths

CONSENT

The above information is accurate and complete to the best of my knowledge. The undersigned hereby authorizes the Doctor to perform all the necessary procedures deemed appropriate for my dental needs.

Patient Signature (Guardian, if Minor) Date

Dentist Signature Date