Ezra Medical Center
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Brooklyn, NY 11218
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MEDICAL/DENTAL HEALTH QUESTIONNAIRE

Date: ___/___/____

Date of Birth: ____/___/____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Occupation: _____
School: _____

Name and Tel # Of Physician: _____
Date of Last Physical Exam: _____
Date of Last Dental Exam: _____

PAST MEDICAL HISTORY

Have you had or do you currently have any of the following:

Cardiac Diseases/Heart Problems (eg. Chest pain, irregular heartbeat, Congenital Heart Disease/Congestive Heart Failure/Hearth Murmur)	Y	N
High/Low Blood Pressure	Y	N
Endocrine problems	Y	N
Diabetes	Y	N
Lungs Disease /Breathing problems (eg. Asthma, shortness of breath, wheezing, coughing)	Y	N
Kidneys Disease (eg. Kidney Stones, Kidney Transplant)	Y	N
Liver Disease/ Hepatitis Type___	Y	N
HIV	Y	N
Thyroid Problems	Y	N
Gastrointestinal Problems (eg. Heartburn, Crohns Disease/Celiac Disease, stomach pain, diarrhea, vomiting)	Y	N
Pregnant? Last Pregnancy? _____	Y	N
Psychiatric Disorder/ Depression	Y	N
Neurological Disease	Y	N
Seizures Disorder	Y	N

Do you have a transplant? (e.g. Liver, Heart, Kidney ect.)	Y	N
Developmental Disabilities (eg. ADD, ADHD, AUTISM, and DOWN SYNDROME ect.)	Y	N
Musculoskeletal problems (eg. Arthritis, Muscles aches, joint pains, swollen joints)	Y	N
Osteoporosis	Y	N
History of Joint replacement?	Y	N
Skin problems (eg. Eczema, Rashes, excessive dryness)	Y	N
Do you use Tobacco? Or do you Smoke?	Y	N
Do you drink Alcohol? If yes how often? ___	Y	N
Do you have a history of narcotics/drugs abuse?	Y	N
Do you have or have had a history of Cancer?	Y	N
Have your ever been hospitalized?	Y	N
Reason:		
Have you ever had surgery?	Y	N
Reason:		

Please see reverse side

Do you have any allergies? Y / N Please list them: _____
Allergies to Latex? Y/N
Allergies to Penicillin? Y/N
Please List all the names and dosages of any medications that you are currently taking including birth control:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Past Dental History

Do you have anxiety about going to the dentist?	Y	N
Do you brush your teeth? How often? Mornings? __ Evenings? __ Bedtimes? __	Y	N
Do you floss?	Y	N
Do you use Fluoride toothpaste or Rinse?	Y	N
Do you have pain when you eat?	Y	N
Do you have pain when you chew?	Y	N
Do you have any of the followings: (Dry mouth, Loose teeth, broken/fractured teeth, cavities, etc.)	Y	N
Have you ever had an Oral Cancer Screening?	Y	N
Do you grind your teeth?	Y	N
(**For Children ONLY***) Is Patient, (nursing, using bottles)	Y	N
Does patient have a habit of* (Finger habit(thumb sucking), nail biting, pacifier, blankets, other_____)	Y	N

Have you had any of the following?		
Braces	Y	N
Oral Surgery/Extractions	Y	N
Root Canal	Y	N
Crowns/Bridges	Y	N
Implants	Y	N
Periodontal Disease or Gum Surgery	Y	N
Removable Dentures	Y	N
Dental Trauma	Y	N
Facial Surgery/ Cleft Palate, etc.	Y	N
Oral Cancer	Y	N

I hereby certify that the information provided above is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I hereby consent to receive dental care and treatment including but not limited to lab work, radiographs, study models, photographs, other diagnostic aids, exams, injections, use of nitrous oxide/laughing gas, dental fillings, extractions, anesthesia (local), and use of behavior management techniques and passive restraint as may be deemed appropriate by Ezra Medical Center personnel.

I authorize Ezra Medical Center to release any information, including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or other healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I may be financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date: ___/___/_____

Relationship to Patient:

_____