Amit Pandya D.D.S. P.C.

1575 Hillside Avenue, Suite 207, New Hyde Park, NY 11040

Phone: (516)-233-2135 Website: www.goinGGrin.com

THANK YOU FOR SELECTING OUR DENTAL HEALTHCARE TEAM! WE WILL STRIVE TO PROVIDE YOU WITH THE BEST POSSIBLE DENTAL CARE.

Patient Information

Date _____

Name _____ Birthdate _____

Last First Middle

Gender: M F Height_____ Weight _____ SS#_____

Address _____ Driver's License #_____

City _____ State_____ Zip Code_____

Phones: Home _____ Cell_____ Work _____

Occupation _____ **Email Address**_____

Name of Spouse/ Closest Relative_____

Whom May We Thank For Referring You?_____

Primary Insurance Information / Responsible Party

Name of Insured Person/ Parents/ Guardian _____ Birthdate _____

Relationship to Patient _____ SS# or ID # _____

Name of Employer _____ Group # _____

Name of Insurance Company _____

Secondary Insurance Information / Responsible Party

Name of Insured Person/ Parents/ Guardian _____ Birthdate _____

Relationship to Patient _____ SS# or ID # _____

Name of Employer _____ Group # _____

Name of Insurance Company _____

Pharmacy Information :

Name _____, Phone _____

Address _____

Amit Pandya D.D.S. P.C.

Medical History

Physician _____ Office Phone _____

Date of Last Exam _____

1. Are you in good health? _____ Yes No
2. Has there been any change in your general health within the past year? _____ Yes No
3. Have you been hospitalized for any surgical operation or serious illness? _____ Yes No
4. Are you taking any medication(s)? Including non-prescription Medicine Yes No
   If yes, which medication(s)? _____
5. Do you use tobacco, alcohol, cocaine, or any other drugs? _____ Yes Yes No
6. Do you or have you had any of the following?

High Blood Pressure	Yes No	Heart Disease	Yes No	Mitral Valve Prolapse	Yes No
Heart Attack	Yes No	Cardiac Pacemaker	Yes No	Chest Pains	Yes No
Rheumatic Fever	Yes No	Heart Murmur	Yes No	Stroke	Yes No
Swollen Ankles	Yes No	Angina	Yes No	Hay Fever/Allergies	Yes No
Fainting/Seizures	Yes No	Frequently Tired	Yes No	Tuberculosis	Yes No
Asthma	Yes No	Anemia	Yes No	Radiation Therapy	Yes No
Low Blood Pressure	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Epilepsy/Convulsions	Yes No	Cancer	Yes No	Recent Weight Loss	Yes No
Leukemia	Yes No	Arthritis	Yes No	Liver Disease	Yes No
Diabetes	Yes No	Joint Replacement/Implant	Yes No	Respiratory Problems	Yes No
Kidney Disease	Yes No	Hepatitis/Jaundice	Yes No	Thyroid Problem	Yes No
AIDS or HIV Infection	Yes No	Easily Winded	Yes No	Stomach Troubles/Ulcers	Yes No
Sexually Transmitted Disease					Yes No

Other _____

7. Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. novocaine)	Yes No	Sulfa Drugs	Yes No
Barbiturates	Yes No	Sedatives	Yes No
Penicillin or other Antibiotics	Yes No	Iodine	Yes No
Aspirin	Yes No	Other	Yes No

Dental History

8. Do your gums bleed while brushing or flossing? Yes No
9. Do you feel pain to any of your teeth? Yes No
10. Do you have any sores or lumps in your mouth? Yes No
11. Have you had any head, neck or jaw injuries? Yes No
12. Are you wearing removable dental appliances? Yes No
13. Are you wearing contact lenses? Yes No
14. Have you had any serious trouble associated with any previous dental treatment? Yes No

Women

15. Are you pregnant? _____ Yes No
16. Are you nursing? _____ Yes No
17. Are you taking birth control pills? Yes No
18. Do you have any problems associated with your menstrual period? _____ Yes No Yes No

Chief Dental Complaint _____

Authorization and Release

I certify that I read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Today's Date _____

Signature of Patient or Parent if Minor

Doctor's Comments _____