KEW Dental Care
30+ years of family dentistry
DR. ROBERT BERGIDA | DR. SETH FAIGEN | (718) 849.9472

116-14 Metropolitan Ave
Kew Gardens, NY 11418 USA
www.kewdentalcare.com

PATIENT INFORMATION **CONFIDENTIAL** DATE_____PATIENT#_____

PATIENT NAME

PATIENT NAME_____ BIRTHDATE_____HOME PHONE_____

ADDRESS_____ CITY_____ STATE_____ZIP CODE_____

E-MAIL_____ CELL PHONE_____

CIRCLE APPROPRIATE: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

OCCUPATION_____ EMPLOYER_____WORK PHONE_____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE_____ CITY_____ STATE_____

IS THIS PERSON A PATEINT IN OUR OFFICE? NO YES

IN CASE OF EMERGENCY PLEASE CONTACT _____PHONE_____

NAME OF PERSON RESPONSIBLE FOR HIS ACCOUNT_____RELATIONSHIP TO PATIENT_____

ADDRESS_____ BEST PHONE TO REACH THEM_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

DENTAL INSURANCE INFORMATION IF YOU HAVE DENTAL INSURANCE COMLPETE THE FOLLOWING

INSURANCE COMPANY_____ GROUP#_____ UNION OR LOCAL #_____

INSURANCE CO. ADDRESS _____ CITY_____STATE_____ZIP_____

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

BIRTHDATE_____ SS#/SIN_____ DATE EMPLOYED_____

NAME OF EMPLOYER_____ WORK PHONE_____

ADDRESS OF EMPLOYER_____ CITY_____ STATE_____ ZIP_____

COVERAGES

BASIC_____
MINOR_____
MAJOR_____
ORTHO_____
MISC_____
YEARLY
MAX_____

DO YOU HAVE A SECONDARY DENTAL INSURANCE? NO / YES IF YES, INFORM THE STAFF FOR A SECOND FORM

SLEEP HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH SLEEP APNEA? NO / YES

HAVE YOU EVER BEEN TOLD TO WEAR A CPAP MACHINE? NO / YES IF YES, ARE YOU COMPLIANT? NO / YES

ARE YOU DROWSY DURING THE DAY, ABLE TO TAKE NAPS AT ANY TIME? NO / YES

DO YOU GET A RESTFUL NIGHTS SLEEP? NO / YES

HAVE YOU EVER HAD A SLEEP STUDY? NO / YES IF YES DOCTOR'S NAME AND LOCATION_____

DO YOU SNORE? NO / YES

DO YOU SUFFER FROM ACID REFLUX? NO / YES

PATIENT MEDICAL HISTORY

PATIENT NAME

PHYSICIAN_____OFFICE PHONE_____DATE OF LAST EXAM_____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED?	☐	☐
3. LIST ANY MEDICATIONS EVEN OVER THE COUNTER		
_____		
_____		
_____		
4. DO YOU USE ALCOHOL?	☐	☐
5. DO YOU USE TOBBACCO?	☐	☐
6. DO YOU USE COCAINE OR OTHER DRUGS?	☐	☐
7. DO YOU TAKE ORAL/INJECTABLE BISPHOSPHONATES	☐	☐

8. ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	NOVOCAINE	☐	☐	BARBITUATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN	☐	☐	SEDATIVES	☐	☐	OTHER
☐	☐	SULFA DRUGS	☐	☐	IODINE			_____

	YES	NO
9. DO YOU HAVE A PERSISTANT COUGH NOT ASSOCIATED WITH AN ILLNESS (LASTING MORE THAN THREE YEARS)	☐	☐
10. WOMEN ONLY		
A) ARE YOU PREGANT OR THINK YOU MIGHT BE	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL?	☐	☐

11. DO YOU HAVE OR HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	ASTHMA	☐	☐	KIDNEY DISEASE
☐	☐	LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	THYROID PROBLEM
☐	☐	HEART ATTACK	☐	☐	EASILY WINDED	☐	☐	ANEMIA
☐	☐	CARDIAC PACEMAKER	☐	☐	ALLERGIES	☐	☐	CANCER
☐	☐	ANGINA	☐	☐	TUBERCULOSIS	☐	☐	ARTHRITIS
☐	☐	CHEST PAINS	☐	☐	RESPIRATORY PROBLEMS	☐	☐	JOINT REPLACEMENT
☐	☐	STROKE	☐	☐	HAY FEVER	☐	☐	LEUKEMIA
☐	☐	HEART MURMUR	☐	☐	ARE YOU TAKING STEROIDS	☐	☐	RADIATION THERAPY
☐	☐	SWOLLEN ANKLES	☐	☐	AIDS OR HIV INFECTION	☐	☐	CHEMOTHERAPY
☐	☐	RHEUMATIC FEVER	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	STOMACH ULCERS
☐	☐	FREQUENTLY TIRED	☐	☐	HEPATITIS	☐	☐	GLAUCOMA
☐	☐	FAINTING SEIZURES	☐	☐	LIVER DISEASE	☐	☐	RECENT WEIGHT LOSS
☐	☐	EPILEPSY/CONVULSIONS	☐	☐	DIABETES	☐	☐	OTHER_____

COMMENTS

_____

_____

_____

_____

_____

_____

_____

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING/FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEETS?	☐	☐
4. DO YOU FEEL ANY PAIN IN ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN / NEAR YOUR MOUTH?	☐	☐
6. DO YOU HAVE ANY HEAD, NECK, OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER HAD ANY OF THE FOLLOWING IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT EAR OR SIDE OF FACE)?	☐	☐
C) DIFFICULTY CHEWING?	☐	☐

	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. WERE YOUR WISDOM TEETH EXTRACTED?	☐	☐
11. HAVE YOU EVER HAD DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING AFTER AN EXTRACTION?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT WAY TO BRUSH YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORAMTION CAN BE DANGEROUS TO MY HEALTH.

X_____