Fred B. Kastenbaum, D.M.D.,LLC
580 Park Avenue
New York, NY 10065

Name:			Date:
Residence- Street:	City:	Zip:	Home Phone:
Business Name:			Work Phone:
Business Address:			Cell Phone:
Position:			Email:
Single/Married?	Spouse Name:		Date of Birth:
Referred by:			Soc. Sec. No.
Physician's Name:			
Physician's Address:			
Telephone:			
Emergency Contact:			Telephone:
Purpose of Visit:			

	Yes	No
1. Do you need to pre-medicate for dental treatment?	☐	☐
2. Have you been under the care of a physician in the past two years?	☐	☐
3. Have you been hospitalized in the past two years?	☐	☐
4. Are you allergic to any drugs or medicine?	☐	☐
5. Have you ever had any excessive bleeding requiring special treatment?	☐	☐
6. (Women) Are you pregnant now?	☐	☐

Check any of the following which you have been or are now being treated for.

☐ Abnormal Blood Pressue	☐ Epilepsy	☐ Persistent Cough
☐ Anemia	☐ Glaucoma	☐ Psychiatric Treatment
☐ Asthma	☐ Heart Disease	☐ Rheumatic Fever
☐ Arthritis	☐ Heart Murmur	☐ Sinus Trouble
☐ Autoimmune Deficiency Syndrome (AIDS)	☐ Hepatitis	☐ Stroke
☐ Blood Disease	☐ Hip/Knee replacement	☐ Tuberculosis of Lung Disease
☐ Diabetes	☐ Jaundice	☐ Ulcers

	Yes	No
7. Have you had any other serious illness?	☐	☐

8. Please list any medications you are presently taking _____

_____

9. Please add anything else which would affect your dental treatment:

SIGNATURE _____

Office Policy: Our office has a 24 hour cancellation policy. If you need to change your appointment, kindly give us enough time to fill your slot. Thank you.