

**ALL AMERICAN SMILE DENTAL STUDIOS, PC.**

**Maurice J. Benjamin & Associates**

**161 Madison Avenue  
New York, NY 10016**

**Tel: 212-252-8893  
Fax: 212-252-8895**

**Date:** \_\_\_\_\_

**Please check one of the following for your visit today:**

\_\_\_ Emergency Treatment. Are you in pain? Yes/No

\_\_\_ Routine Dental Care (Dental Examination & Treatment)

\_\_\_ Consultation

What way you prefer to be contacted (circle): Phone / Email

Patient's E-Mail: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Tel: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

In case of emergency, please contact \_\_\_\_\_ Tel: \_\_\_\_\_

Dental Insurance: Name \_\_\_\_\_ Tel: \_\_\_\_\_

Address: \_\_\_\_\_ Group: \_\_\_\_\_

Referred By: \_\_\_\_\_

Member (if other than patient) Name: \_\_\_\_\_

Member's SS#: \_\_\_\_\_ DOB \_\_\_\_\_

Member Employed by: \_\_\_\_\_

Are you the **Primary Card** holder for this plan? YES/ NO

Physician's (MD) Name \_\_\_\_\_ Tel: \_\_\_\_\_

Date of last dental examination: \_\_\_\_\_

Date of last series of Complete mouth x-rays: \_\_\_\_\_

Are you in good health?	YES	NO
Do your gums bleed?	YES	NO
Are you happy with your smile?	YES	NO
Do you smoke?	YES	NO
Are your teeth yellow?	YES	NO
Would you like to change your smile?	YES	NO
Would you like to WHITEN your teeth?	YES	NO

Have you ever been PRE-MEDICATED with antibiotics before any dental treatment? YES/NO

List ALL hospitalizations and serious illnesses, including dates:

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**DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING:**

Have you ever been diagnosed with a Heart Murmur/Mitral Valve?	YES	NO
Rheumatic Fever or Rheumatic heart Disease?	YES	NO
Heart attack, angina, or other heart disease?	YES	NO
Prosthetic or Artificial heart valve?	YES	NO
Irregular Heart beat or pacemaker?	YES	NO
Shortness of breath after mild exercise?	YES	NO
High Blood Pressure?	YES	NO
Swollen Ankles?	YES	NO
Asthma, emphysema, or difficulty breathing?	YES	NO
Stroke, Seizure, or convulsions?	YES	NO
Diabetes?	YES	NO
Recent increase in thirst?	YES	NO
Recent increase in urination?	YES	NO
Thyroid Problems?	YES	NO
Kidney trouble or Renal Dialysis?	YES	NO
Hepatitis, liver disease, or jaundice?	YES	NO
Stomach ulcers or stomach problems?	YES	NO
AIDS, ARC, HIV infection?	YES	NO
Arthritis or rheumatism?	YES	NO
Prosthetic or Artificial joint?	YES	NO
Venereal disease?	YES	NO
Cancer, radiation treatment, Chemotherapy?	YES	NO

Blood disorder, bleeding tendency or frequent bruising?	YES	NO
Psychiatric treatment?	YES	NO
Tuberculosis?	YES	NO
Persistent cough or coughing up blood?	YES	NO
Enlarged lymph nodes or swollen glands?	YES	NO
Hearing or Vision problems?	YES	NO
Auto immune disease or lupus erythematosus?	YES	NO
Do you have allergies?	YES	NO
If Yes, what? _____		
Have you ever taken Penicillin?	YES	NO
Have you ever had a bad reaction to any drug or medication?	YES	NO
If yes, what ( ) Penicillin or any other antibiotic		
( ) Dental anesthetic ( ) Codeine or other narcotics		
( ) Aspirin ( ) Other		

WOMEN: Are you Pregnant YES NO

Please list all of the medications you are now taking:

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**THE FOLLOWING CHARGES WILL BE ASSESSED FOR:**

Missed/Broken Appts without 24HR notice	\$75
Surgical Appts Broken less than 48HRS	\$150
Bounced Checks	\$25

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_.