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:

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 desease?	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 erythematousus?	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:

_____

_____

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: _____.