alan r. kantro, d.m.d.
1729 deer park avenue
deer park, ny 11729
(631) 667-2542

Date: ____/____/____

Dear New Patient,

Welcome to our office! We sincerely appreciate your choosing us as your dental office. We understand that you may be feeling a bit apprehensive about your first visit, but don't worry, this is very natural. In order for us to put you at ease and to get to know you better, it is very important for you to answer the following questions accurately. Please take your time. Thanks for your help, and again, welcome!

Name: _____
(Last) (First) (Middle)

Street Address: _____

City, State, Zip Code: _____

Telephone Numbers: _____
(Home) (Business)

Cell Phone/E-mail: _____
(Cell Phone) (E-mail)

Date of Birth: ____/____/____ Age: _____ Soc. Sec. No.: _____-_____-_____

Sex: [M] [F] Ht.: _____ Wt.: _____

Occupation: _____ Employer: _____

Marital Status: [S] [Mar] [Div] [Wid] Spouse's Name: _____

Dental Insurance Company: _____ Policy ID# _____

Reason for Today's Visit? _____

Most Convenient Appointment Day of Week/Time: _____/_____

Who can we thank for REFERRING YOU? _____

I consent to whatever dental procedures and anesthetics that are considered necessary for the proposed treatment. I also permit the release of any information to or from my physician as may be required.
I agree to assume full financial responsibility for all the dental treatment rendered. I also permit Dr. Alan R. Kantro to use any pre-operative and post-operative photographs obtained during treatment.

_____ _____
Signature of Patient, Parent/Guardian Date Signature of Dentist/Witness Date

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DENTAL HISTORY: GENERAL

Are you having any discomfort at this time? _____

How long since you have seen a dentist? _____

Are your teeth sensitive to: Heat ____ Cold ____ Sweets ____ Sour ____ Other ____

Have you ever had gum treatments? _____ When? _____ By whom?_____

Do you currently have bleeding gums? _____ Does food wedge between your teeth? _____

Where does food wedge between your teeth? _____

Do you clench or grind your teeth? _____ When? _____

Have you had your teeth straightened? _____ When? _____ By whom?_____

Do you feel you have bad breath at times? _____ When? _____

Do you have an unpleasant taste in your mouth? _____ When? _____

Do you have any pain in or around your ears? _____ Where? _____

Do you hear popping, clicking, or snapping when you chew? _____

Are there any lumps or swelling in your mouth? _____ Where? _____

Do you have any fear of dentistry? _____

DENTAL HISTORY: ESTHETIC

Do you like to smile? _____ If not, why not? _____

Are your teeth:

Chipped ____ Protruding ____ Hidden ____ Discolored ____ Crooked ____ Large ____ Spaces ____

Do you like the shape of your teeth? _____

Are there any fillings or caps you don't like looking at? _____

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MEDICAL HISTORY:

Physician's Name: _____ Phone #: _____

Date of Last Physical Exam: _____ For what? _____

Blood Pressure: _____/_____ Are you taking any medications? Yes _____ No _____

List Medications: _____

Do you have any of the following (please indicate with a check-mark):

Any Heart Disease	☐	Allergies to Medicines or Drugs	☐	Psychiatric Care	☐
Heart Murmur	☐	Any Other Allergies:	☐	Rheumatic Fever	☐
Mitral Valve Prolapse	☐			Scarlet Fever	☐
High Blood Pressure	☐	Asthma	☐	Typhoid Fever	☐
Low Blood Pressure	☐	Diabetes	☐	Tonsillitis	☐
Circulatory Problems	☐	Hepatitis	☐	Tuberculosis	☐
Nervous Problems	☐	Herpes	☐	Ulcer	☐
Radiation Treatments	☐	AIDS	☐	Venereal Disease	☐
Excessive Bleeding	☐	Malignancies (Cancer)	☐	Are You Pregnant?	☐
Blood Transfusions	☐	Measles	☐	Emphysema	☐
Anemia	☐	Mumps	☐	Hay Fever	☐
Stroke	☐	Artificial Heart Valve	☐	Thyroid Disease	☐
Heart Pacemaker	☐	Artificial Joint	☐	Kidney Trouble	☐
Sinus Problems	☐	Chemotherapy	☐	Arthritis	☐
Rheumatism	☐	Glaucoma	☐	Cortisone Medicine	☐
Liver Disease	☐	Drug Addiction	☐	Hemophilia	☐
Epilepsy	☐	Fainting or Dizzy Spells	☐	Sickle Cell Disease	☐
Do you smoke?	☐	Is there anything that you would like to add? (use the space below)			