DRAGOS SANDULESCU D.D.S.

*608 Fifth Avenue, Suite 808 New York N.Y. 10020 * 212-245-5817*
*2000 North Village Avenue, Suite 206 Rockville Centre N.Y. 11570 * 516-208-5501*

Patient's name _____ Preferred name _____ Birth date_____
Home phone _____ Work phone _____ Cell Phone_____ _____
Mailing address _____ City _____State _____ Zip _____
Employer _____ Occupation _____
Spouse's name _____ Spouse's Phone Number _____
Whom may we thank for referring you to our office? _____

Your Social Security number: _____ Dental Insurance Co._____ Group number_____
Covered by spouse's insurance? ❑ yes ❑ no
Spouse's dental insurance company _____ Group number _____
Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____
  _____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Signature of patient (or parent) _____ Date _____

Patient Dental History

Name of previous dentist_____ Date of last dental exam_____

	Yes	no		yes	no
Do your gums bleed----------	☐	☐	Do you have headaches------	☐	☐
Are your teeth sensitive ------	☐	☐	Do you clench/grind ----------	☐	☐
Do you bite your cheeks------	☐	☐	Do you have any sores--------	☐	☐
Have your teeth shifted------	☐	☐	Do you wear a retainer-------	☐	☐

Do you have problems with your jaw joint?---------- ☐ ☐

Have you ever had complications from past dental experiences?---------- ☐ ☐

Please include details----------

Have you ever had trouble getting numb or had any adverse reactions-------- ☐ ☐

Are you fearful of dental treatment---------- ☐ ☐

Is there anything about your smile that you would like to change---------- ☐ ☐

Please be specific----------

Have you ever whitened (bleached) your teeth---------- ☐ ☐

Have you ever been treated for gum disease---------- ☐ ☐

Is there anyone with a history of periodontal disease in your family---------- ☐ ☐

What is your immediate concern today?----------

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THI INFORMATION. PLEASE REVIEW IT CAREFULLY.

We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care tha you receive. For example, your health information may be shared with other-providers to whom you are referred. Information may be shared b paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorizatio to disclose information you can later revoke it to stop any future uses and disclosures. Our legal duty: We are required by law to protect the privac of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seel your acknowledgment of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policie we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more informatio about our privacy policies, contact the person listed below.

If you have any questions or complaints, please contact: Anca Sandulescu (practice ADMINISTRATOR) 516-208-5501

Acknowledgment of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received both layers of this Notice of Privacy Practices. Then return this acknowledgment of receipt to the receptionist or to the address above.

NAME :_____ SIGNATURE:_____ DATE:_____