



DR. ANTHONY CLASSI | DR. IRENA MAUSNER

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NEW PATIENT PROFILE

DATE _____

NAME _____
LAST FIRST MIDDLE

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____
HOME WORK CELL

DATE OF BIRTH _____ AGE _____ S.S.# _____

EMAIL _____

SEX MALE FEMALE MARITAL STATUS SINGLE MARRIED DIVORCED WIDOWED OTHER _____

COMPANY NAME & ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

OCCUPATION _____

REFERRED BY _____

EMERGENCY CONTACT NAME _____
LAST FIRST

EMERGENCY CONTACT TELEPHONE _____

DATE OF LAST DENTAL EXAMINATION _____

DATE OF LAST SERIES OF COMPLETE MOUTH X-RAYS _____

Are you in good health?	YES	NO
Has there been any change in your general health within the past five years?	YES	NO
Do your gums bleed when you brush?	YES	NO
Are you happy with your smile?	YES	NO
Do you smoke cigarettes, cigars, or pipes?	YES	NO
Are your teeth yellow?	YES	NO
Would you like to change your smile?	YES	NO
Whiten your teeth?	YES	NO
Do you have any problem eating certain foods?	YES	NO
Do you have sensitivity to hot or cold foods?	YES	NO
Have you ever been Pre-Medicated with antibiotics before any dental treatment?	YES	NO
Did you ever have orthodontics?	YES	NO
If yes, how many years _____ at what age _____		

LIST ALL HOSPITALIZATIONS AND SERIOUS ILLNESSES, INCLUDING DATES

HOSPITALIZATION/ILLNESS	DATE
HOSPITALIZATION/ILLNESS	DATE
HOSPITALIZATION/ILLNESS	DATE

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING:

Diagnosed with a Heart Murmur/Mitral Valve?	<input type="checkbox"/>	Rheumatic Fever or Rheumatic Heart Disease?	<input type="checkbox"/>
Heart attack, angina, or other heart disease?	<input type="checkbox"/>	Prosthetic or Artificial heart valve?	<input type="checkbox"/>
Irregular heartbeat or pacemaker?	<input type="checkbox"/>	Shortness of breath after mild exercise?	<input type="checkbox"/>
High Blood Pressure?	<input type="checkbox"/>	Swollen Ankles?	<input type="checkbox"/>
Asthma, emphysema, or difficulty breathing?	<input type="checkbox"/>	Recent increase in thirst?	<input type="checkbox"/>
Stroke, seizures, or convulsions?	<input type="checkbox"/>	Stomach ulcers or stomach problems?	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	AIDS, ARC, HIV infection?	<input type="checkbox"/>
Recent increase in urination?	<input type="checkbox"/>	Arthritis or rheumatism?	<input type="checkbox"/>
Thyroid Problems?	<input type="checkbox"/>	Prosthetic or Artificial joint?	<input type="checkbox"/>
Kidney trouble or Renal Dialysis?	<input type="checkbox"/>	Cancer, radiation treatment, or chemotherapy?	<input type="checkbox"/>
Hepatitis, liver disease, or jaundice?	<input type="checkbox"/>	Venereal disease? Syphilis? Gonorrhoea?	<input type="checkbox"/>
Tuberculosis?	<input type="checkbox"/>	Persistent cough or coughing up blood?	<input type="checkbox"/>
Psychiatric treatment?	<input type="checkbox"/>	Enlarged lymph nodes or swollen glands?	<input type="checkbox"/>
Autoimmune disease or lupus erythematosus?	<input type="checkbox"/>	Hearing problem or vision problems?	<input type="checkbox"/>
Blood disorder, bleeding tendency, or frequent bruising?	<input type="checkbox"/>		

DO YOU HAVE ANY 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 other antibiotic
 Aspirin
 Dental anesthetic
 Codeine or other narcotics
 Other _____

[WOMEN ONLY]

ARE YOU PREGNANT? YES NO

LIST ALL OF THE DRUGS OR MEDICATIONS YOU ARE TAKING NOW:

Name of Medication	Dosage	How Long	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ARE YOU UNDER THE CARE OF A PHYSICIAN? YES NO

PLEASE PROVIDE THE MD'S NAME, ADDRESS, AND PHONE NUMBER:

NAME	ADDRESS	TELEPHONE
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IN ADDITION TO THOSE YOU HAVE LISTED, HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS OR DRUGS WITHIN THE PAST YEAR? IF YES, PLEASE CHECK THE APPROPRIATE BOX

- | | | | |
|----------------------------------------------------------|--------------------------|------------------------------------|--------------------------|
| Medication for asthma | <input type="checkbox"/> | Aspirin, arthritis/pain medication | <input type="checkbox"/> |
| Medication for anxiety (nerves) | <input type="checkbox"/> | Methadone maintenance | <input type="checkbox"/> |
| Medication for depression or a disorder | <input type="checkbox"/> | Cortisone/other steroids | <input type="checkbox"/> |
| Medication for a heart problem | <input type="checkbox"/> | Medication for high blood pressure | <input type="checkbox"/> |
| Nitroglycerin or any medication for angina or chest pain | <input type="checkbox"/> | Insulin or pills for diabetes | <input type="checkbox"/> |
| Anticoagulants (blood thinners) | <input type="checkbox"/> | AZT/other drugs for HIV infection | <input type="checkbox"/> |
| Medication for stomach ulcers | <input type="checkbox"/> | Other: _____ | <input type="checkbox"/> |
| Cancer, Chemotherapy | <input type="checkbox"/> | | |

I UNDERSTAND AND AUTHORIZE CLASSI COSMETIC & IMPLANT DENTIST OF NYC TO TAKE ALL DIAGNOSTIC MATERIALS NEEDED TO MAKE A FINAL DIAGNOSIS OF DENTAL TREATMENT. DIAGNOSTIC MATERIALS MAY INCLUDE INTRA-ORAL PICTURES, RADIOGRAPHS, DIGITAL RADIOGRAPHS, DIAGNOSTIC MODELS, PHOTOGRAPHS, AND SLIDES. THIS MATERIAL MAY BE USED FOR LECTURES, ARTICLES, AND/OR PUBLICATIONS.

I AUTHORIZE CLASSI COSMETIC & IMPLANT DENTIST OF NYC TO PERFORM AND/OR ADMINISTER ANY AND ALL FORMS OF TREATMENT, MEDICATION, AND ANESTHESIA THAT MAY BE NECESSARY. I UNDERSTAND THAT THE DENTAL TREATMENT PRESENTED TO ME IS MY FINANCIAL RESPONSIBILITY AND THAT ALL FEES FOR SERVICES ARE DUE AND PAYABLE UP FRONT AND/OR AT THE COMPLETION OF TREATMENT AS AUTHORIZED BY CLASSI COSMETIC & IMPLANT DENTIST OF NYC AND/OR ADMINISTRATOR.

I WILL ASSUME RESPONSIBILITY OF NOTIFYING THE CLASSI COSMETIC & IMPLANT DENTIST OF NYC OF ANY CHANGES IN MY MEDICAL HISTORY OR CONTACT INFORMATION.

I UNDERSTAND THAT CLASSI COSMETIC & IMPLANT DENTIST OF NYC RESERVES THE RIGHT TO CHANGE THE TERMS OF ITS NOTICE OF PRIVACY PRACTICES, AND TO MAKE CHANGES REGARDING ALL PROTECTED HEALTH INFORMATION RESIDENT AT, OR CONTROLLED BY, THIS PRACTICE. I UNDERSTAND I CAN OBTAIN THIS PRACTICE'S CURRENT NOTICE OF PRIVACY PRACTICES ON REQUEST.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES.

WE RESERVE THE RIGHT TO CHARGE OUR PATIENTS A FEE FOR APPOINTMENTS THAT ARE BROKEN OR NOT CANCELLED WITH 24 HOUR NOTICE.

PATIENT'S SIGNATURE _____

DATE _____