Madeline Shakin DDS Kevin Sheren DDS PC

369 East Main Street, Suite 9, East Islip, NY 11730 (631)581-1188

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Height: _____ Weight: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work) _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact _____ Relationship _____ Phone: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

- Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No
  If yes, please explain: _____

Have you ever had any of the following? Please check those that apply:

☐ Allergies _____	☐ Epilepsy	☐ Kidney Disease	☐ Stomach Problems
	☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke
_____	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
	☐ Glaucoma	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ High Cholesterol	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Hay Fever	☐ Pregnancy	☐ Venereal Disease
☐ Artificial Joints	☐ Head Injuries	Due date: _____	☐ Smoking
☐ Asthma	☐ Heart Disease	☐ Radiation Treatment	
☐ Blood Disease	☐ Heart Murmur/MVP	☐ Respiratory Problems	OTHER:
☐ Cancer	☐ Hepatitis	☐ Rheumatic Fever	☐ _____
☐ Diabetes Type I or II	☐ High Blood Pressure	☐ Reflux	
☐ Dizziness	☐ Jaundice	☐ Sinus Problems	☐ _____

- **Name of Physician:** _____ **Phone:** _____
- Have you been admitted to a hospital or needed surgery during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking or have you taken any prescription or over the counter medicine(s)?
  If so, please list all: _____
  _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian