LI SOUND
DENTAL
SOLUTIONS

DAVID KAHN DMD | MATTHEW KAHN DDS

159 ROUTE 25A, SUITE 1C, MILLER PLACE, NY 11765 | 631-509-4486

Welcome to our office. We appreciate the confidence you place in us to provide your oral health services. To assist us in serving you, please complete the following form. The information provided on this form is important to a dental health. If you have any questions regarding the completion of this form, please do not hesitate to ask.

PATIENT INFORMATION

First Name: _____ Last Name: _____ Sex: ☐Male ☐Female
Birth Date: _____ Age: ____ SS#: _____ Email: _____
Street:_____ Apt: _____ City: _____ State: _____ Zip: _____
Home #: ( ) _____ - _____ Cell #: ( ) _____ - _____ Referred By: _____
Employer: _____ Work #: ( ) ____ - _____ Driver's Lic.#: _____
Emergency Contact #1: _____ Tel.# ( ) _____ - _____ Relation: _____
Emergency Contact #2: _____ Tel.# ( ) _____ - _____ Relation: _____
Pharmacy Name: _____ Tel.# ( ) _____ - _____
Person Responsible For Account: ☐Self ☐ Parent ☐Spouse ☐Other: _____
First Name: _____ Last Name: _____ Sex: ☐Male ☐Female
Birth Date: _____ Age: ____ SS#: _____ Email: _____
Street:_____ Apt: _____ City: _____ State: _____ Zip: _____
Home #: ( ) _____ - _____ Cell #: ( ) _____ - _____
Employer: _____ Work #: ( ) ____ - _____ Driver's Lic.#: _____

INSURANCE INFORMATION

Student: ☐Full-Time ☐Part-Time School:_____
Marital Status: ☐Married ☐Divorced ☐Single ☐Widow ☐Legally Separated
Employed: ☐Full-Time ☐Part-Time ☐Retired ☐Unemployed
Primary Dental Insurance: _____ ID:_____ Employer: _____
Bus. Address _____ Bus. Tel.#: ( ) _____ - _____
Ins. Address _____ Ins. Tel.#: ( ) _____ - _____
Group #: _____ Insured Party: _____ Relation: _____
Sex: ☐Male ☐Female Birth Date: _____ Age: ____ SS#: _____ Tel.#: ( ) ____ - _____
Street:_____ Apt: _____ City: _____ State: _____ Zip: _____
Secondary Dental Insurance: _____ ID:_____ Employer: _____
Bus. Address _____ Bus. Tel.#: ( ) _____ - _____
Ins. Address _____ Ins. Tel.#: ( ) _____ - _____
Group #: _____ Insured Party: _____ Relation: _____
Sex: ☐Male ☐Female Birth Date: _____ Age: ____ SS#: _____ Tel.#: ( ) ____ - _____
Street:_____ Apt: _____ City: _____ State: _____ Zip: _____

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MEDICAL HISTORY QUESTIONNAIRE

Please read through the following and check all that apply.

Chronic Pain Disorders			Gastrointestinal Disease		
Osteoarthritis	☐Yes	☐No	Colitis/Diverticulitis	☐Yes	☐No
Fibromyalgia	☐Yes	☐No	Acid Reflux/Heartburn	☐Yes	☐No
Other: _____			Ulcer/Gastritis	☐Yes	☐No
Infectious Disease			**Heart/Blood Disorders**		
Hepatitis	☐Yes	☐ No	High Blood Pressure	☐Yes	☐No
Herpes/Sexually Transmitted Disease	☐Yes	☐No	Anemia	☐Yes	☐No
HIV/AIDS	☐Yes	☐No	Bleeding/Bruising Disorder	☐Yes	☐No
Mononucleosis	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Behavioral Disorder			Artherosclerosis/Coronary Artery Disease	☐Yes	☐No
Depression	☐Yes	☐No	Chest pain/Angina	☐Yes	☐No
Anxiety	☐Yes	☐No	Heart Attack	☐Yes	☐No
ADD/ADHD	☐Yes	☐No	Heart Murmur or Damaged Heart Valves	☐Yes	☐No
Other: _____			Atrial Fibrillation	☐Yes	☐No
Other Conditions					
Sinusitis	☐Yes	☐No	Kidney Disease	☐Yes	☐No
Glaucoma	☐Yes	☐No	Liver Disease or Jaundice	☐Yes	☐No
Swollen Ankles	☐ Yes	☐ No	Other: _____		

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MEDICAL HISTORY QUESTIONNAIRE CONTINUED

Cancer/Neoplastic Disease		
Cancer	☐Yes	☐No
Leukemia	☐Yes	☐No
Lymphoma	☐Yes	☐No

Immune System Disorder		
Rheumatoid Arthritis	☐Yes	☐No
Sjogren's Syndrome	☐Yes	☐No
Lupus Erythematosus	☐Yes	☐No
Other:		

Lung/Airway Disorders		
Emphysema	☐Yes	☐No
Pneumonia	☐Yes	☐No
Asthma	☐Yes	☐No
Bronchitis	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Sleep Apnea	☐Yes	☐No
Other: _____		

Neurological Disease		
Epilepsy/Seizure/Fainting Disorder	☐Yes	☐No
Neuralgia	☐Yes	☐No
Headache/migraines	☐Yes	☐No
Stroke	☐Yes	☐No
Other: _____		

Genetic Disorder		
_____ _	☐Yes	☐No

Metabolic/Hormonal Disorders		
Diabetes	☐Yes	☐No
Thyroid	☐Yes	☐No
Adrenal	☐Yes	☐No
Other: _____		

Woman Patients Only		
Are you pregnant or is there a possibility of pregnancy	☐Yes	☐No
Are you nursing	☐Yes	☐No
Do you take hormones or oral contraceptives	☐Yes	☐No
Have you reached menopause	☐Yes	☐No

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PLEASE LIST ALL PAST HOSPITALIZATIONS, SURGERIES OR BLOOD TRANSFUSIONS

	Month/Year	Reason
1		
2		
3		
4		
5		

PLEASE LIST ALL MEDICATIONS AND OVER-THE-COUNTER REMEDIES YOU ARE CURRENTLY TAKING OR HAVE TAKEN IN THE PAST

	Medication	Indication	Dose
1			
2			
3			
4			
5			
6			
7			

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ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Penicillin	☐Yes	☐No	Aspirin	☐Yes	☐No
Other antibiotic _____	☐Yes	☐No	Metals _____	☐Yes	☐No
Local Anesthetic	☐Yes	☐No	Latex	☐Yes	☐No
Codeine or other Narcotics	☐Yes	☐No	Iodine	☐Yes	☐No
Sulfa Drugs	☐Yes	☐No	Sulfites	☐Yes	☐No
Barbiturates or other Sedatives	☐Yes	☐No	Foods _____	☐Yes	☐No
Amoxicillin	☐Yes	☐No	Any other allergies?_____		

PLEASE INDICATE IF YOU HAVE A HISTORY OF ANY OF THE FOLLOWING

Do you have a condition that requires antibiotic prophylaxis prior to invasive dental treatment ?	☐Yes	☐No
Have you ever received any ☐ radiation therapy or ☐chemotherapy	☐Yes	☐No
Do you take any ☐blood thinners or ☐aspirin?	☐Yes	☐No
Have you taken steroids within the last 2 years?	☐Yes	☐No
Have you ever received an ☐artificial heart valve or ☐vascular graft?	☐Yes	☐No
Have you ever had an ☐organ transplant, ☐joint replacement or received an ☐implantable device such as a pacemaker	☐Yes	☐No
Have you ever taken a diet pill such as phen-phen	☐Yes	☐No
Have you ever taken bisphosphonates such as ☐Recast, ☐Boniva, ☐Prolia, ☐Fosamax, ☐Zometa, ☐Acedia, or ☐Actonel to increase bone density	☐Yes	☐No
Do you use any controlled substances?	☐Yes	☐No

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SOCIAL HISTORY

Please indicate if you have a history of any of the following.

Number of caffeinated beverages consumed daily: ☐0 ☐1-2 ☐3-5 ☐6+	Have you ever used tobacco products in the past?	☐Yes	☐No
Number of alcoholic drinks you consume weekly: ☐0 ☐1-2 ☐3-5 ☐6-10 ☐11+	Do you currently use tobacco products now?	☐Yes	☐No
Number of carbonated beverages daily: ☐0 ☐1-2 ☐3-5 ☐6+	☐Cigarette ☐Pipe/cigar ☐Smokeless		
Are you currently using marijuana or any street drugs? ☐Yes ☐No Type: _____	Average number of uses per day: _____		
Have you traveled outside the country in the last 21 days? ☐Yes ☐No	For how many years? _____		

DENTAL HISTORY

Please answer the following questions.

Are you apprehensive about dental treatment?	☐Yes	☐No
Have you had problems with prior dental treatment?	☐Yes	☐No
Do you like your smile?	☐Yes	☐No
Do you want complete dental care?	☐Yes	☐No
Does food get caught between your teeth?	☐Yes	☐No
Do you like the appearance of your teeth?	☐Yes	☐No
Do you have trouble chewing your food?	☐Yes	☐No
Do you have problems with bleeding gums?	☐Yes	☐No
Do you avoid brushing any part of your mouth because of pain?	☐Yes	☐No
Have you ever noticed slow-healing sores in your mouth	☐Yes	☐No

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Dental History Continued.

Do you take fluoride supplements?	☐Yes	☐No
Do you wear dentures?	☐Yes	☐No
Do you sleep with a night guard?	☐Yes	☐No
Do you grind or clench your teeth?	☐Yes	☐No
Have you been told you have TMJ (temper mandibular joint) disorder?	☐Yes	☐No
Has anyone ever told you that you gasp for air or snore while sleeping?	☐Yes	☐No
Do you have a history of trauma or injury to the head and neck region?	☐Yes	☐No
Do you frequently wake with a headache?	☐Yes	☐No
Are you excessively tired during the day?	☐Yes	☐No
Have you ever noticed slow-healing sores in your mouth?	☐Yes	☐No
Do you currently use a APAP, BPAP, CPAP or other sleep apnea device?	☐Yes	☐No

How many times a day do you brush? ☐Never ☐Daily ☐Twice ☐Three times or more

How many times a day do you floss? ☐Never ☐Daily ☐Twice ☐Three times or more

HEALTH CARE RESOURCES

Primary Care Physician: _____ Phone Number:_____

Address: _____ Date of last visit: _____

Specialist/Field: _____ Phone Number:_____

Address: _____ Date of last visit: _____

Specialist/Field:_____ _____ Phone Number:_____

Address: Date of last visit:

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CARE QUESTIONNAIRE

At LI Sound Dental Solutions we aim to make your time with us as pleasant as possible. Please read through the following and check all that apply.

- ☐ I gag easily.
- ☐ I feel out of control when I'm lying in a dental chair.
- ☐ I have not been to the dentist in a long time and I am afraid of what will be said about my teeth or my oral hygiene.
- ☐ I am aware of my habits that cause harm to my teeth and I am afraid that I may not be able to break them.
- ☐ Pain relief is my top priority.
- ☐ I don't like shots. Needles make me nervous
- ☐ I like as much information as possible so that I can make informed decisions.
- ☐ My teeth are very sensitive.
- ☐ My gums are very sensitive.
- ☐ Scraping sounds bother me.
- ☐ The sound of the drill makes me anxious.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ I want to know the cost up front. No money surprises, please.
- ☐ I have difficulty remembering what was discussed while I was in the dental chair.
- ☐ I have questions that I would like answered before I sit down in the dental chair.
- ☐ I don't like being left alone in the treatment area.
- ☐ I do not want to see the instruments that you will be using in my mouth.
- ☐ I get dizzy when you tip the chair too far back.
- ☐ My back hurts when you tip the chair too far back.
- ☐ I prefer to have nitrous oxide sedation during dental treatment.

Other concerns that I would like to bring to your attention: _____

_____

Why are you here today? _____

_____

Please answer the check the following regarding how we may contact you regarding appointment information.

Home phone: ☐Yes ☐No Can we leave a message? ☐Yes ☐No

Cell phone: ☐Yes ☐No Can we send a text message? ☐Yes ☐No

Business phone: ☐ Yes ☐No Can we leave a message? ☐Yes ☐No

Email: ☐Yes ☐No

Can we leave messages with the following if they answer your home phone and you are not available to come to the phone? ☐ spouse ☐ parent ☐ sibling ☐ child