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 General and Cosmetic Dentistry

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WELCOME TO OUR PRACTICE!

We strive to give our patients the best quality of care. We feel that your personal

comfort and dental health are very important. We use some of the newest and safest

techniques in our treatments. Please feel free to ask questions and let us know of

any concerns you may have prior to treatment.

***PATIENT INFORMATION:***

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title (i.e. Mr. Mrs. Ms. Etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drivers License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State Issued \_\_\_\_\_\_\_\_\_\_\_\_ Exp Date \_\_\_\_\_\_\_\_\_\_\_

Check any that Apply: Minor Single Married Divorced Widowed Separated

Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_

Whom May We Thank For Referring You? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person To Contact in Case of Emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

***DENTAL INSURANCE:***

Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID (SS# if MetLife) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***DENTAL HISTORY:***

Reason For Today's Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_

Date of Last Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Dental X-rays \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check all That Apply:

 Bad Breath Bleeding Gums Clicking or popping in Jaw

 Cold Sores Food Impaction Grinding of Teeth

 Loose Teeth Broken Fillings Periodontal Treatment

 Orthodontic Treatment Cold Sensitivity Hot Sensitivity

 Sweet Sensitivity Sensitivity When Biting Ear Pain

 Swelling Injuries to Head or Mouth Previous use of Gas/Nitrous

## How Often do You Floss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often Do You Brush \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with oral cancer? Yes No

Has anyone in your family been diagnosed with Oral Cancer? Yes No

## *MEDICAL HISTORY:*

Physicians Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any serious illnesses Yes No

If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Women): Are you pregnant? Yes No Nursing? Yes No

Taking Birth Control Pills? Yes No If so, What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any of the following:

 Auto Immune Disease Epilepsy Nutritional Disorders

 Anemia - Iron Deficiency Fainting Spells/Seizures Pacemaker

 Artificial Heart Valves Heart Murmur Psychiatric Care

 Artificial Joints Heart Problems Radiation Treatment

 Asthma Hepatitis Rheumatic Fever

 Back Problems High/Low Blood Pressure Thyroid Problems

 Blood Disorders HIV +/AIDS Tobacco Habit

 Cancer Jaw Pain Tonsillitis

 Chemical Dependency Kidney Disease Tuberculosis

 Chemotherapy Liver Disease Ulcer

 Diabetes Mitral Valve Prolapse Venereal Disease

 Hemophilia Respiratory Disease

Are you currently taking any medications? Yes No

 Antibiotic Aspirin (daily) Anticoagulants: blood thinners

 Blood Pressure Heart Medication Anti-Depressants

 Cortisone (steroids) Other

If you have checked any of theseboxes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic or have you had any adverse reactions to:

 Local Anesthetics Penicillin Other Antibiotics

 Aspirin Codeine

 Other: Please Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_

Please notify us of any changes of employment, address, and phone number or medical status.

Dental and Medical History Reviewed Orally with Patient

Clinician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_