Dr. Jacob J. Kirsch, DDS **Dr. Dylan T. Sallerson, DDS**

115 W. 86th St, Suite 1A
New York, NY 10024

PERSONAL INFORMATION

Patient Name _____ Birthdate _____ Phone Number _____
Street Address _____ Apt/Suite # _____ City _____ State_____
Zip _____Gender ___ Preferred Pronoun _____E-Mail_____
Social Security #_____ Emergency Contact Information _____
Who referred you? _____

DENTAL INSURANCE INFORMATION

Insurance Carrier _____ Group Number _____ Pharmacy Name/# _____
Employer _____ Subscriber Name (and D.O.B.) _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around the oral cavity, which is a singular part of the entire party, health problems that you may have, or medications you may be taking, could have an important relationship with the dental care you receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No If yes, please explain: _____
Have you ever been hospitalized/had a major operation? O Yes O No If yes, please explain: _____
Have you ever had a serious head or neck injury? O Yes O No If yes, please explain: _____
Are you taking any medications, pills, or drugs? O Yes O No If yes, please explain: _____
Do you use tobacco? O Yes O No Do you use controlled substances? O Yes O No
Please answer to the best of your ability: *do you have, or have you had, any of the following?*

O Aids/HIV+	O Circulatory Problems	O Mitral Valve Prolapse
O Anemia	O Diabetes	O Nervous Problems
O Angina	O General Allergies	O Psychiatric Care
O Arthritis Gout	O Anesthetics Allergy	O Radiation Treatment
O Artificial Heart Valve	O Mint Allergy	O Respiratory Disease
O Artificial Joint	O Other Allergy	O Rheumatic Fever
O Asthma	O Heart Problems	O Special Diet
O Antibiotic Prophylaxis	O High Blood Pressure	O Swollen Neck Glands
O Blood Thinner	O Headaches/Migraines	O Sinus Problems
O Cancer	O Hemophilia	O Ulcer
O Chemical Dependency	O Hepatitis, Jaundice	O Weight Loss

Any drug allergies or ever have any adverse reaction to medicine? _____
Women Are you Pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No
Anything else to report on your medical history? _____

The above information is accurage and completed to the best of my knowledge. I understand that this information will be used for my treatment, billing, and processing of insurance beneftis for which I am entitled. I will not hold my dentist/his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ **Date**_____

Dr. Signature _____ **Date**_____