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Name _____
Home Address _____
City, State Zip _____
Email Address _____

Today's Date _____
Date of Birth _____
Social Security Number _____
Home Phone _____
Business Phone _____

Patient Medical History

- Are you under medical treatment now?
Yes No
- Have you ever been hospitalized for any surgical operation or serious illness?
Yes No
- Are you taking any medication(s) including non-prescription medicine? Yes No
If yes, which medication(s)? _____
- Do you use tobacco? Yes No
- Do you use alcohol, cocaine or other drugs? Yes No
- Are you wearing contact lenses? Yes No
- Are you allergic to or have you had any reactions to the following:
Local Anesthetics (e.g. Novocain) Yes No
Penicillin or other antibiotics Yes No
Sulfa Drugs Yes No
Barbiturates Yes No
Sedatives Yes No
Iodine Yes No
Aspirin Yes No
Other Yes No
- Women Only:*
a) Are you pregnant? Yes No
b) Are you nursing? Yes No
c) Are you taking birth control pills? Yes No
- Do you have or have you had any of the following?

High Blood Pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Frequently Tired	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Angina	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hepatitis/Jaundice	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Stomach Troubles/Ulcers	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hay Fever/Allergies	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Joint Replacement/Implant	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Radiation Therapy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Recent Weight Loss	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Respiratory Problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Other	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Physician _____
Office Phone _____
Date of Last Exam _____
Emergency Contact Name _____
Emergency Contact Number _____

Patient Dental History

- Do your gums bleed while brushing or flossing? Yes No
- Are your teeth sensitive to hot or cold liquids/foods? Yes No
- Are your teeth sensitive to sweet or sour liquids/foods? Yes No
- Do you feel any pain to any of your teeth?
Yes No
- Do you have any sores or lumps in or near your mouth? Yes No
- Have you had any head, neck, or jaw injuries? Yes No
- Have you ever experienced any of the following problems in your jaw?

	Yes	No
a) Clicking?	<input type="checkbox"/>	<input type="checkbox"/>
b) Pain (joint, ear, side of face)?	<input type="checkbox"/>	<input type="checkbox"/>
c) Difficulty in opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>
d) Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>
- Do you have frequent headaches?
Yes No
- Do you clench or grind your teeth?
Yes No
- Do you bite your lips or cheeks frequently?
Yes No
- Have you ever had any difficult extractions in the past?
Yes No
- Have you had any orthodontic work?
Yes No
- Have you ever had prolonged bleeding following extractions? Yes No
- Have you ever had instruction on the correct method of brushing your teeth?
Yes No
- Have you ever had instructions on the care of your gums? Yes No

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered.

Signed _____ Date _____