

Cary H. Ganz D.D.S.  
Suite 400  
400 Garden City Plaza  
Garden City, N.Y. 11530

Date:     /     /

Dear New Patient,

**Welcome to our office!** We sincerely appreciate your choosing us as your dental office and look forward to your becoming a part of our family of patients. We understand that you may be feeling a bit apprehensive about today's visit but don't worry, this is a very natural feeling. We know that there are many thoughts going through your mind. In order for us to put you at ease and to get to know you better, **it is very important for you to answer the following questions accurately.** Please take your time. Thank you for your help.

**Name:** \_\_\_\_\_  
(Last) (First) (Middle)

**Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_  
(Home) (Business)

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** (M) (F) **Ht.:** \_\_\_\_\_ **Wt.:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Marital Status:**(Single)(Married)(Divorced)(Widowed) **Spouse's Name:**\_\_\_\_\_

**Dental Insurance Co.:**\_\_\_\_\_ **Soc. Sec. No.:**\_\_\_\_\_

**What is the reason for today's visit?**\_\_\_\_\_

**Most Convenient Appointment Time:**\_\_\_\_\_ **Day of the Week:**\_\_\_\_\_

**Who can we thank for REFERRING YOU:**\_\_\_\_\_

I consent to whatever dental procedures and anesthetics that are considered necessary for the proposed treatment. I also permit the release of any information to or from my physician as may be required.

I agree to assume full financial responsibility for all the dental treatment rendered. I also permit Dr. Ganz to use any pre-operative and post-operative photographs obtained during treatment.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Signature of Dentist/Witness

Date / /

**Dental History: General**

Are you having any discomfort at this time ? \_\_\_\_\_ How long since you have seen a dentist ? \_\_\_\_\_

Are your teeth sensitive to :  Heat  Cold  Sweets  Sour Other \_\_\_\_\_

Have you ever had gum treatments? \_\_\_\_\_ When? \_\_\_\_\_ By whom? \_\_\_\_\_

Do you currently have bleeding gums? \_\_\_\_\_ Does food wedge between your teeth? \_\_\_\_\_ Where? \_\_\_\_\_

Do you clench or grind your teeth? \_\_\_\_\_ When? \_\_\_\_\_

Have you had your teeth straightened? \_\_\_\_\_ When? \_\_\_\_\_ By Whom? \_\_\_\_\_

Do you feel you have bad breath at times? \_\_\_\_\_ When? \_\_\_\_\_ Unpleasant taste? \_\_\_\_\_

Any pain in or around your ears? \_\_\_\_\_ Do you hear popping, clicking or snapping when you chew? \_\_\_\_\_

Are there any lumps of swelling in your mouth? \_\_\_\_\_ Do you have any fear of dentistry ? \_\_\_\_\_

**Dental History: Esthetic**

Are your teeth:  Chipped  Protruding  Hidden  Discolored  Crooked  Large Spaces

Do you like the shape of your teeth? \_\_\_\_\_ Are there any fillings, caps you don't like looking at? \_\_\_\_\_

Do You Like Your Smile? \_\_\_\_\_ If not, why? \_\_\_\_\_

**Medical History:**

Physician's Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_ For what? \_\_\_\_\_

Blood Pressure: / Are You Taking Any Medications: (Y) (N) What? \_\_\_\_\_

Do you have any of the following :( *Please indicate with a check mark*)

- |  |  |   |
|--|--|---|
| Any Heart Disease----- <input type="checkbox"/>  | Allergies to medicines or drugs-- <input type="checkbox"/> | Psychiatric Care----- <input type="checkbox"/>  |
| Heart Murmur----- <input type="checkbox"/>       | Any other Allergies ----- <input type="checkbox"/>         | Rheumatic Fever----- <input type="checkbox"/>   |
| Mitral Valve Prolapse-- <input type="checkbox"/> | _____  | Scarlet Fever----- <input type="checkbox"/>     |
| High Blood Pressure--- <input type="checkbox"/>  | Asthma----- <input type="checkbox"/>                       | Typhoid Fever----- <input type="checkbox"/>     |
| Low Blood Pressure--- <input type="checkbox"/>   | Diabetes----- <input type="checkbox"/>                     | Tonsillitis----- <input type="checkbox"/>       |
| Circulatory Problems-- <input type="checkbox"/>  | Hepatitis----- <input type="checkbox"/>                    | Tuberculosis----- <input type="checkbox"/>      |
| Nervous Problems----- <input type="checkbox"/>   | Herpes----- <input type="checkbox"/>                       | Ulcer----- <input type="checkbox"/>             |
| Radiation Treatments-- <input type="checkbox"/>  | AIDS----- <input type="checkbox"/>                         | Venereal Disease---- <input type="checkbox"/>   |
| Excessive Bleeding--- <input type="checkbox"/>   | Malignancies (Cancer) ----- <input type="checkbox"/>       | Are You Pregnant?-- <input type="checkbox"/>    |
| Blood Transfusions--- <input type="checkbox"/>   | Measles----- <input type="checkbox"/>                      | Emphysema----- <input type="checkbox"/>         |
| Anemia----- <input type="checkbox"/>             | Mumps----- <input type="checkbox"/>                        | Hay Fever----- <input type="checkbox"/>         |
| Stroke----- <input type="checkbox"/>             | Artificial Heart Valve----- <input type="checkbox"/>       | Thyroid Disease----- <input type="checkbox"/>   |
| Heart Pacemaker----- <input type="checkbox"/>    | Artificial Joint----- <input type="checkbox"/>             | Kidney Trouble----- <input type="checkbox"/>    |
| Sinus Problems----- <input type="checkbox"/>     | Chemotherapy----- <input type="checkbox"/>                 | Arthritis----- <input type="checkbox"/>         |
| Rheumatism----- <input type="checkbox"/>         | Glaucoma----- <input type="checkbox"/>                     | Cortisone Medicine-- <input type="checkbox"/>   |
| Liver Disease----- <input type="checkbox"/>      | Drug Addiction----- <input type="checkbox"/>               | Hemophilia----- <input type="checkbox"/>        |
| Epilepsy----- <input type="checkbox"/>           | Fainting or Dizzy Spells----- <input type="checkbox"/>     | Sickle Cell Disease--- <input type="checkbox"/> |
| Do you SMOKE? ---- <input type="checkbox"/>      |  |   |

**Do Your Feel That There Is Anything That You Would Like To Add?** \_\_\_\_\_