

ROBERT B . TRACEY, D.D.S.



11 Medical Park Drive • Pomona, NY 10970

Welcome to our office.

To enable us to treat you, we ask that you please take the time to fill out the information requested below.
Thank you.

Today's Date _____ E-Mail Address _____

Patient's Name _____

Address _____
No. Street City State Zip

Date of Birth _____ Sex _____ Ht. _____ Wt. _____

Home Phone _____ Work Phone _____

Cell Phone _____ Patients S.S. # _____

May we contact you at your place of business? Yes _____ No _____ Employer _____

Marital Status _____ Name of Spouse or Nearest Relative _____

Best days and time for appointments _____
Days Time

Who may we thank for referring you to our office? _____

FINANCIAL AND INSURANCE INFORMATION

Who is responsible for this account? _____

Name of primary dental insurance _____ Employed by _____

Name of insured _____ Insured's S.S. # _____ Group # _____

Insured Date of Birth _____ ID# _____

Name of secondary dental insurance _____ Employed by _____

Name of insured _____ Insured's S.S. # _____ Group # _____

Date of Birth _____ ID# _____

Name of medical insurance _____ Group # _____

DENTAL HISTORY

Why did you seek dental care at this time? _____

Date of your last dental visit _____

Nature of your last dental visit _____

Have you had problems with dental treatment or a dental office in the past? _____

Explain _____

If recent x-rays were taken, shall we send for them? _____ Name, Phone No. _____

When was your last thorough dental examination? _____

Do you have regular check ups? _____ How often? _____

What kind of shape are your teeth and gums in? _____

If you could change anything about your teeth and gums, what would it be?

1) _____

2) _____

3) _____

Does your jaw click when you open & close? Yes _____ No _____

Do you clench or grind your teeth? Yes _____ No _____

Do you have pain on the side of your face or near your ear? Yes _____ No _____

Do you have a bad taste in your mouth? Yes _____ No _____

Do your gums bleed? Yes _____ No _____

Are your teeth sensitive to cold? Yes _____ No _____

What type of toothbrush do you use? Soft Medium Hard Don't know

Do you floss regularly? Yes _____ No _____

Are you taking any of the following medications?

Antibiotics _____ Blood pressure medicine _____

Anticoagulants _____ Heart medications _____

Tranquilizers _____ Cortisone _____

Digitalis _____ Water pills _____

Nitroglycerine _____ Aspirin _____

Any other medications not listed? _____

WOMEN: Are you pregnant? Yes _____ No _____

Are you nursing? Yes _____ No _____

Are you taking oral contraceptives? Yes _____ No _____

Is there anything else we should know about your medical history that we didn't ask? _____

I certify that I have read and understand the above and have answered all the questions correctly, to the best of my knowledge. If I have any changes in my health, I will notify the dentist.

Date _____ Signature _____

MEDICAL HISTORY UPDATE

DATE

CHANGES IN MEDICAL HISTORY