A. Art Kaslow, DDS

We Welcome You

Take a moment to fill out this form so we can know you better.

New Patient Information

Patient Name _____ ☐ M ☐ F SS# _____

DOB __ __ / __ __ / __ __ __ __ Age _____ Employer/School _____
M M D D Y Y Y Y

MAILING ADDRESS

Street _____ APT _____ Phone #1 _____
Cell ☐ Work ☐ Home ☐

City _____ State _____ Phone #2 _____
Cell ☐ Work ☐ Home ☐

Zip Code _____ E-Mail _____

EMERGENCY CONTACT PERSON – Name _____ Relation to Patient _____

Street _____ APT _____ Phone _____
Cell ☐ Work ☐ Home ☐

City _____ State _____ ZIP _____

HOW DID YOU HEAR ABOUT US?

Friend/Relative ☐ TV/Radio ☐ Internet Search ☐ Print Advertisement ☐ Driving By ☐ Mailer ☐

Full Name _____ OTHER ☐ (Please Specify) _____

What Brought You to Us?

Visiting today because _____

Do you require/request sedation dentistry? Yes ☐ No ☐ Don't Know ☐ Learn more ☐

SERVICES YOU'RE INTERESTED IN

☐ Orthodontics / Invisalign
☐ Tooth Replacement (implant or bridge)
☐ Botox
☐ Dentures
☐ Cleaning & Exam
☐ Replacing Silver Fillings
☐ Cosmetic Dentistry
☐ Zoom Whitening

CONSENT TO PROCEED

I authorize A. Art Kaslow, DDS Doctors or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or any minor or other individuals for which I have responsibility, including arrangement and/or administration of any sedative, restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effect(s), which may include numbness, bruising and muscle soreness. I do voluntarily assume any and all risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired result, which may or may not be achieved, for my benefit or my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

_____ _____
Signature of patient, legal guardian or authorized agent Date

Your Medical History

SERIOUS ILLNESS, OPERATIONS or HOSPITAL VISITS IN THE PAST 5 YEARS

Explain _____

_____

_____

ALLERGIES

☐ Local Anesthetics ☐ Penicillin or Other ☐ Aspirin ☐ Codeine, Valium or Other ☐ Sulfa Drugs

☐ Latex ☐ Iodine ☐ Barbiturates, sedatives or sleeping pills ☐ Nitrous Oxide ☐ Other _____

_____

FOR WOMEN

Pregnant or Trying ☐ Yes ☐ No Nursing ☐ Yes ☐ No Birth Control/Hormone Replacement ☐ Yes ☐ No

LIST ALL CURRENT MEDICATIONS *(including over the counter)*

_____

_____

_____

DISEASES OR PROBLEMS (Please check box if Yes)

☐ Abnormal Bleeding
☐ AIDS/HIV Infections
☐ Anemia
☐ Angina
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Arthritis
☐ Asthma
☐ Blood Transfusion
☐ Cancer / Chemotherapy
☐ Chest Pain Upon Exertion
☐ Continuous Positive Airway Pressure (CPAP)
☐ Diabetes
☐ Drug Addiction
☐ Emphysema
☐ Epilepsy
☐ Fainting / Seizures
☐ Gastrointestinal
☐ Glaucoma
☐ Headache / Migraine
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Problems
☐ Mental Health
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Rapid Weight Loss
☐ Recurrent Infections
☐ Rheumatic Fever
☐ Rheumatoid Arthritis
☐ Sinus Trouble
☐ Sleep Apnea
☐ Sleep Study
☐ Snore
☐ Sores / Ulcers
☐ Stomach Ulcers
☐ Stroke
☐ Thyroid Problems
☐ Toothache
☐ Sensitivity to Chewing
☐ Tuberculosis
☐ Sexually Transmitted Diseases

NAMES AND PHONE NUMBERS OF CURRENT DOCTORS PROVIDING CARE

_____

_____

_____

I hereby certify that the above answers to the following questions are accurate to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent visit.

_____ _____

Signature of patient, legal guardian or authorized agent Date

Please email this form to info@artkaslowdds.com