

Health Questionnaire  
Bard J. Levey D.D.S., PLLC  
914-271-6224

Date \_\_\_\_\_

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone(home): \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Physician's Name and Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Name of Dental Insurance (if applicable): \_\_\_\_\_

Occupation: \_\_\_\_\_

If insurance coverage is through your spouse, spouses name: \_\_\_\_\_

Spouses date of birth and SSN(if applicable) \_\_\_\_\_

Referred By: \_\_\_\_\_

Have you received medical treatment during the past year Y/N For what? \_\_\_\_\_

Have you had a skin reaction to jewelry? Yes No

What medicines are you (your child) currently taking? \_\_\_\_\_

Please review information on back of page

Women: Are you pregnant? \_\_\_\_\_ Taking birth control pills? \_\_\_\_\_ Nursing? \_\_\_\_\_  
 PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU (YOUR CHILD) HAVE HAD, OR  
 NOW HAVE:

- |                          |   |                      |
|--------------------------|---|----------------------|
| Heart Disease or Attack  | A.I.D.S./HIV Pos                                    | Diabetes             |
| Angina Pectoris          | Hepatitis A (Infectious)                            | Emphysema            |
| High Blood Pressure      | Hepatitis B (Serum)                                 | Tuberculosis (TB)    |
| Heart Murmur             | Hepatitis C (non-A, non B)                          | Asthma               |
| Rheumatic Fever          | Blood Transfusions                                  | Allergies or Hives   |
| Congenital Heart Lesions | Drug Addictions                                     | Cortisone Medication |
| Mitral Valve Prolapse    | Hemophilia (Bleeding Problems)                      | Arthritis            |
| Heart Pacemaker          | Epilepsy or Seizures                                | Glaucoma             |
| Heart Surgery            | Liver Disease                                       | Radiation Treatment  |
| Artificial Joints        | Psychiatric Treatment                               | Pain in Jaw Joints   |
| Kidney Trouble           | Alcoholism  | Hay Fever            |
| Stroke                   | Chemotherapy (Cancer, Leukemia)                     |                      |
| Sinus Trouble            | Anemia  | Thyroid Disease      |
| Ulcers                   | Venereal Disease (syphilis, Gonorrhea, Herpes, etc) |                      |
| Other _____              |   |                      |

ARE YOU ALLERGIC TO, OR HAVE YOU REACTED ADVERSELY TO, ANY OF THE  
 FOLLOWING?

- |              |               |            |                  |
|--------------|---------------|------------|------------------|
| Aspirin      | Nitrous Oxide | Penicillin | Tetracycline     |
| Metals       | Latex         | Codeine    | Local Anesthesia |
| Erythromycin | Sedatives     | Any Other? |                  |

Please give the name and telephone number of the closest relative or friend (not living with you)  
 to contact in case of emergency: Name \_\_\_\_\_ Phone: \_\_\_\_\_

To the best of my knowledge, all answers are correct. I will notify Dr. Levey if any changes in my  
 health or medication should occur. I consent to necessary treatment being performed on me by Dr. Levey  
 and his staff, and also to the use of photos for educational and commercial purposes. Also, I understand  
 that the administration of local anesthetic may cause an untoward reaction or side effects, which may  
 include, but are not limited to bruising, hematoma; cardiac stimulation; temporary or rarely, permanent  
 numbness; or muscle soreness. I understand that occasionally needles may break and require surgical  
 retrieval.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_