**STANLEY E. KACHERSKI, D.D.S., M.S., P.C.**
Clove Branch Professional Center
129 Clove Branch Road
Hopewell Junction , New York 12533

# MEDICAL HISTORY

DATE ______________________________
NAME ______________________________
ADDRESS ____________________ PHONE __________
CITY __________ STATE __________ ZIP __________
______________

OCCUPATION ______________ PHONE __________
WORK ADDRESS ______________________________
SOCIAL SECURITY NO. ______________________
BIRTHDAY ______________ SEX: ___M ___F
SPOUSE ______________ NO. OF CHILDREN ___
PARENT OR GUARDIAN (IF UNDER 18) ______________

CELL PHONE # ______________

DENTAL INSURANCE:
1. ______________________________
2. ______________________________
WHO WILL PAY FOR THIS ACCOUNT?

REFERRED BY ______________________
PHYSICIAN NAME ______________________
PHYSICIAN ADDRESS ______________________
PHYSICIAN PHONE NO. ______________________
REASON FOR DENTAL VISIT ______________________
______________________________

Signature ______________

MEDICAL HISTORY: Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information.

| HAVE YOU EVER HAD OR HAVE? | YES | NO |
|---|---|---|
| 1. Asthma, hay fever, sinusitis .or other allergies | | |
| 2. Allergy to penicillin, aspirin, local or general anesthetic, or other drugs; specify | | |
| 3. Blood pressure or heart problems | | |
| 4. Rheumatic fever or heart murmur | | |
| 5. A pacemaker or open heart surgery | | |
| 6. Diabetes, liver, kidney, thyroid, or lung problems | | |
| 7. Ulcers or stomach problems | | |
| 8. Hepatitis or jaundice | | |
| 9. Epilepsy or nervous disorders | | |
| 10. Bleeding or clotting disorders | | |
| 11. Arthritis, autoimmune diseases, bone disorders, joint replacement | | |
| 12. Venereal Disease, herpes, sexual transmitted disease | | |
| 13. Acquired Immune Deficiency Syndrome (AIDS) | | |
| 14. Any other illness | | |
| 15. Do any wounds heal slowly or present complications? | | |
| 16. Are you presently taking any medicine? Specify: | | |
| 17. Are you presently under the care of a physician? | | |
| 18. When was your last physical exam? | | |
| 19. Have you ever been hospitalized? | | |
| 20. Have you had X-ray treatments or chemotherapy? | | |
| 21. Are you presently on a diet? | | |
| 22. Women – Are you pregnant? | | |
| 23. What is your tobacco history? | | |