

Please fill out each field and bring this form to your first appointment.

If you have any questions, please call 212.838.2900

You may also mail this form to Michael Krochak DMD, 29 West 57th Street, 6th Floor, New York, NY 10019 or Fax the form to 212.935.4703

First Name _____ Last Name _____

Address _____ City _____

State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Social Security Number _____ Date of Birth _____ / _____ / _____
Month Day Year

Name of Spouse/Partner _____ Referred by _____

If you are completing this form for another person, what is your relationship to that person? _____

MEDICAL HISTORY

For the following questions, check YES or NO, whichever applies. Your answers are for our records only and are confidential.

Are you in good health? Yes No

Has there been any change in your general health within the past year Yes No

My last physical examination was on ____ / ____ / ____

Are you now under the care of a physician? Yes No

If yes, what is the condition being treated?

Please provide the name and address of your physician(s).

Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No

If so, what was the illness or problem?

Please list all medicine(s), including non-prescription medicine, you are taking.

Do you have or have you had any of the following diseases or problems?

Damaged heart valves or artificial heart valves (including heart murmur or rheumatic heart disease) Yes No

Cardiovascular disease (including heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes No

a. Do you have chest pain on exertion? Yes No

b. Are you ever short of breath after mild exercise or when lying down?..... Yes No

c. Do your ankles swell? Yes No

d. Do you have inborn heart defects? Yes No

e. Do you have a cardiac pacemaker? Yes No

- Allergy..... Yes No
- Sinus trouble..... Yes No
- Asthma or hay fever Yes No
- Fainting spells or seizures..... Yes No
- Persistent diarrhea or recent weight loss..... Yes No
- Diabetes Yes No
- Hepatitis, jaundice or liver disease..... Yes No
- Thyroid problems Yes No
- Respiration problems, emphysema, bronchitis, etc..... Yes No
- AIDS or HIV infection..... Yes No
- Stomach ulcer or hyperacidity Yes No
- Kidney trouble Yes No
- Tuberculosis..... Yes No
- Persistent cough or cough that produces blood Yes No
- Persistent swollen glands in neck..... Yes No
- Low blood pressure Yes No
- Sexually transmitted disease Yes No
- Epilepsy or other neurological disease..... Yes No
- Problems with mental health Yes No
- Cancer Yes No
- Problems with immune system Yes No
- Have you had abnormal bleeding? Yes No
- Have you ever required a blood transfusion?..... Yes No
- Do you have any blood disorder?..... Yes No
- Have you ever had any treatment for a tumor or growth?..... Yes No

Are you allergic or have you had a reaction to:

- 1. Local anesthetics Yes No
- 2. Penicillin or other antibiotics Yes No
- 3. Sulfa drugs Yes No
- 4. Barbiturates, sedatives, or sleeping pills..... Yes No
- 5. Aspirin Yes No
- 6. Iodine..... Yes No
- 7. Codeine or other narcotics..... Yes No
- 8. Other: _____ Yes No

Have you had any serious trouble associated with any previous dental treatment?..... Yes No
If so, explain.

Do you have any disease, condition or problem not listed above that you think we should know about?..... Yes No
If so, explain.

Are you wearing contact lenses?..... Yes No
Are you wearing removable dental appliances? Yes No
Do you smoke?..... Yes No
If yes, how much?

Do you drink alcoholic beverages?..... Yes No
If yes, how much and what type:

For women only

- Are you pregnant?..... Yes No
- Do you have any problems associated with your menstrual period? Yes No
- Are you nursing?..... Yes No
- Are you taking birth control pills?..... Yes No

What is your chief dental complaint?

Any significant dental history we should know about?

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

PRINT NAME

SIGNATURE

DATE

If you have any problems or questions regarding these forms, please call our office at 212.838.2900. We will be glad to assist you.

APPOINTMENT PREFERENCE INFORMATION

First Name _____ Last Name _____

First Preference for Appointments

- Early morning (8 AM to 9:30 AM)
- Mid-Morning (9:30 AM to 11:30 AM)
- Lunchtime (12 Noon to 2 PM)
- Mid-afternoon (2 PM to 4 PM)
- Late Afternoon (4 PM to 6 PM)

Second Preference for Appointments

- Early morning (8 AM to 9:30 AM)
- Mid-Morning (9:30 AM to 11:30 AM)
- Lunchtime (12 Noon to 2 PM)
- Mid-afternoon (2 PM to 4 PM)
- Late Afternoon (4 PM to 6 PM)

Contact Preference

- Home Phone: _____ Work Phone: _____
- Cell Phone: _____ Email: _____

We will call you to arrange an appointment at your preferred time and look forward to meeting you!

PATIENT ACCOUNT INFORMATION

First Name _____ Last Name _____

Address _____ City _____

State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Name of Spouse/Partner _____ Spouse/Partner Phone _____

Closest Relative _____ Closest Relative Phone _____

Employer _____ Occupation _____

Business Address (include floor number) _____

City _____ State _____ Zip _____

Person Financially Responsible for Account _____

If different from self: Phone _____ Address _____

City _____ State _____ Zip _____

In an effort to provide you with quality dental care and maintain our present fees by minimizing billing procedures, payment is requested at the time of your visit for all charges \$250 or less. Please check one.

Payment by cash Payment by check Payment by credit card

Dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we provide the following payment options.

If you have dental insurance, a completed dental claim form must be on file with this office. It is also your responsibility to notify us of any changes. For involved treatment greater than \$250, we will accept your insurance assignment towards your bill as long as a definitive arrangement (see options below) is made for your estimated patient responsibility.

Prepayment Courtesy: 5% No-Billing Courtesy for treatment plans of \$2,000 or more. Must be paid 48 hours prior to appointment.

3 Month Interest-Free Option: (Separate form required). 1/3 of total fee is billed either by: 1) Automatic monthly billing to your Visa, Mastercard, Discover or American Express or 2) Automatic monthly debit from your checking account.

CareCredit Plan: No initial payment. Payment plans up to 60 months with monthly payments as low as \$22/month (for a \$1000 balance). Ask in our office for full illustration. Must be approved.

Your insurance is a method for you to receive reimbursement for fees you have paid to the doctor for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages or other limitations based on your contract with them. It is your responsibility to pay the deductible, co-insurance and any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

PRINT NAME

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First Name _____ Last Name _____

Phone _____ Email _____

CORAH'S DENTAL ANXIETY SCALE

If you had to go to the dentist tomorrow, how would you feel about it?

- I would look forward to it as a reasonably enjoyable experience.
- I wouldn't care one way or the other.
- I would be a little uneasy about it.
- I would be afraid that it would be unpleasant and painful.
- So anxious that I sometimes break out in a sweat or almost feel physically sick

When you are waiting in the dentist's office for your turn in the chair, how do you feel?

- Relaxed
- A little uneasy
- Tense
- Anxious
- So anxious that I sometimes break out in a sweat or almost feel physically sick

When you are in the dentist's chair waiting while he gets his drill ready to begin work on your teeth, how do you feel?

- Relaxed
- A little uneasy
- Tense
- Anxious
- So anxious that I sometimes break out in a sweat or almost feel physically sick

You are in the dentist's chair to have your teeth cleaned. While you are waiting and the dentist is getting out the instruments that he will use to scrape your teeth around the gums, how do you feel?

- Relaxed
- A little uneasy
- Tense
- Anxious
- So anxious that I sometimes break out in a sweat or almost feel physically sick

MOUNT SINAI DENTAL FEAR INVENTORY

Please rate the following situations on a scale of 1 to 100.

(1 is so relaxed you could fall asleep and 100 is the point where you are about to faint or become sick)

	10	20	30	40	50	60	70	80	90	100
Sitting in the dentist's waiting room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smelling the smell of a dentist's office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting up in a dental chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reclining in a dental chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing the needle and syringe for anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receiving the anesthetic injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing the noise of the dentist's drill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having a tooth drilled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing the dental probes or instruments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having the dental instruments manipulated in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing the dentist walk into the treatment room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having your teeth cleaned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having dental x-rays taken	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered more than 50 for any question, you have some serious fears that should be addressed.

0-50 - average level of fear or concern 50-80 - high level of fear 80-100 - extreme level of fear

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