

KAREN ALTSZULER, D.D.S. IRVING KESTENBAUM, D.D.S.  
501 MADISON AVE, NEW YORK, N.Y. 10022 (212) 688-2820

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DATE \_\_\_\_\_

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Name (Last) (First) (Middle)

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Home Address: Street City State Zip Code Home Phone

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Employer: Address: Street City State Zip Code

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Business Phone Cell Phone email address

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Date of Birth Sex Height Weight OCCUPATION

MARITAL STATUS: (circle) Single Married Widowed Separated Divorced

Spouse's Name \_\_\_\_\_

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Emergency Contact: Name Relationship Telephone #

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Type of Dental Insurance (if applicable) Social Security Number Most Convenient Appointment Time

**MEDICAL HEALTH**

General Health (please check): EXCELLENT  GOOD  FAIR  POOR

Name and address of Physician \_\_\_\_\_

Last complete physical? \_\_\_\_\_

Are you taking any medication now? Yes  No  For what purpose? \_\_\_\_\_

**Have you ever been treated for: (PLEASE CIRCLE)**

Heart Disease.....	Yes	No	Heart Murmur.....	Yes	No
Rheumatic fever.....	Yes	No	Artificial Heart valves or joints.....	Yes	No
Abnormal Blood pressure.....	Yes	No	Asthma or hay fever.....	Yes	No
Ulcers.....	Yes	No	Sinus trouble.....	Yes	No
Tuberculosis or lung disease.....	Yes	No	Cough.....	Yes	No
Diabetes.....	Yes	No	Hepatitis, Jaundice or Liver Disease.....	Yes	No
Epilepsy.....	Yes	No	Arthritis.....	Yes	No
Anemia.....	Yes	No	Stroke.....	Yes	No
Congenital Heart lesions.....	Yes	No	Glaucoma.....	Yes	No
AIDS.....	Yes	No	HIV virus.....	Yes	No

Have you ever been treated (other than diagnostic) with x-ray?..... Yes No

Are you allergic to: Penicillin  Codeine  Local injected anesthetics  Other medications

Are you subject to prolonged bleeding..... Yes No

Are you subject to fainting spells?..... Yes No

Do you have excessive urination and /or thirst?..... Yes No

(WOMEN) Are you pregnant?..... Yes No How long? \_\_\_\_\_

Signature \_\_\_\_\_