

**ALEXANDER MILNE DDS, PLLC**

Practice Limited to Endodontics

31 QUARRY ST

KINGSTON, NY 12401

Phone: (845) 331- 1640 Fax: (845) 338-0242

(Please Circle)

Mr., Mrs., Ms., Miss.,

Patient First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer (Company Name) \_\_\_\_\_ Work/Cell Number \_\_\_\_\_

Referring Dentist \_\_\_\_\_ Dental Insurance \_\_\_\_\_

Physician \_\_\_\_\_ Physician phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

Have you been hospitalized within the past 2 years? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Have you ever experienced abnormal bleeding? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had surgery or radiation to your head or neck? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have any sensitivity to Latex Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had any reaction to dental anesthetic/ Epinephrine? Yes \_\_\_\_\_ No \_\_\_\_\_

**FOR WOMEN ONLY:** Could you be pregnant now? Yes \_\_\_\_\_ No \_\_\_\_\_

Please **CIRCLE** any of the following which you presently have or have had in the past:

Mitral Valve Prolapse

Liver Disease

Glaucoma

Heart Murmur

Hepatitis

Arthritis

Irregular Heart Beat

Neurological Problems

Malignancy (Cancer)

Rheumatic Fever

Psychiatric Problems

Chemotherapy

Pacemaker

Aids or HIV

Sexually Transmitted Disease

Low Blood Pressure

Asthma

Joint / Hip Replacement

High Blood Pressure

Sinus

Hemophilia

Stroke

Tuberculosis

Chronic Cold Sores

Epilepsy

Ulcers

Nervousness (Panic Attacks)

Kidney Disease

Diabetes

Other Not Listed \_\_\_\_\_

Please List ALL Medications that you are currently taking \_\_\_\_\_

Have you ever had a reaction to any medication \_\_\_\_\_

If yes, which ones? \_\_\_\_\_

What type of reaction \_\_\_\_\_

WARNING! Failure to Disclose Any Past/Present Medical Condition May Adversely Affect Your Care.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

(Parent or guardian if patient is minor)

REVIEWED BY, WITH PATIENT \_\_\_\_\_ DATE \_\_\_\_\_