OLIVIA MASRY D.D.S. & JOYCE LOCKWOOD D.D.S., P.C.

312 CHAPPAQUA ROAD
BRIARCLIFF MANOR, NY 10510

Name_____

Address_____

Home Phone_____ Work Phone_____

Cell Phone_____ DOB_____

Name of Responsible Party_____

Insurance (Y/N)_____ Employer Name_____

Social Security Number_____

Referred By_____ Pharmacy Name & Location_____

Marital Status_____ Email Address_____

Does your medical history include any of the following?

__Heart Ailment	__Liver Disease	__Anemia
__High Blood Pressure	__Arthritis	__Glaucoma
__Respiratory Disease (asthma)	__Thyroid Disease	__Rheumatic Fever
__Kidney Disease	__Tumors	__Prosthetic Heart Valve
__Hepatitis	__Diabetes	__Latex Allergy
__HIV	__Cancer	__Joint Replacement
__Aids	__Mental Illness	__Disabilities
__Venereal Disease	__Bone Replacement Therapy (Foxomax, Boniva, Zometa, etc)	

What medications do you take?_____

Do you have any allergies to medications?_____

Are you in good health?_____ Have you ever been hospitalized?_____

Date of last physical?_____ Physician's Name?_____

Date of last dental visit?_____ Date of last x-rays?_____

Do you have any pain in or near your ears?_____

Are you sensitive to temperature/pressure/sweets?_____ If so, where?_____

Have you received instructions in correct brushing/flossing?_____

Do your gums bleed?_____ Do you have any other health problems not listed?_____

Signature_____ Date_____