

Sheldon A. Grabiner, D.D.S.
Alicia S. Rubinstein, D.D.S.



Name _____
Residence Address _____
Home Phone _____ Cell Phone _____ Business Phone _____
Soc. Sec. # _____ Driver's License # _____
Employed By _____
Present Position _____
Name of Spouse _____ Employed By _____
Spouse Business Phone _____ Present Position _____
In Case of Emergency Contact _____
Referred By _____
Who is responsible for taking care of this account? _____
Name of any dental insurance coverage _____
Policy # _____ Group # _____

MEDICAL HISTORY

Physician's Name _____ Date of last Physical Exam _____
Birthdate _____ Age _____

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

Please indicate with a check mark (✓)

<input type="checkbox"/> Any Heart Problems	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Mitral Valve Prolapse/Heart Murmur	<input type="checkbox"/> Allergies to Anesthetics	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Allergies to Medicines or Drugs	<input type="checkbox"/> Malignancies
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Allergies to _____	<input type="checkbox"/> Bone Disease
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Anemia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Asthma	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Stroke	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Aids/HIV Positive	<input type="checkbox"/> Other
<input type="checkbox"/> Any Joint Replacement	Year of Surgery _____	Orthopedist's Name _____
		Orthopedist's Phone # _____

List all current medication _____

Have you taken any prescription diet medication? _____

Please describe any current medical treatment or impending surgery _____

Date _____ Your Signature _____