Victoria Edelstein D.D.S.

30 E 40th St, Ste 507

New York, N.Y. 10016

(212)297-0357

Cancellation Policy

We ask you to please give us at least 24 hour notice when changing an appointment. Changes or cancellations made less than 24 hours prior notice will result in $45 charge. For appointments longer than 1 hour duration, the charge will be $90. One short notice cancellation is allowed without charge.

I have read and understand the above cancellation policy. I agree to pay for the appointment cancellation with less than 24 hours notice.

Signature: _____ Date: _____

Patient Information

Last Name_____ **First Name** _____

Social Security # _____

Date of Birth _____ ☐ **Male** ☐ **Female**

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Street Address_____

City _____ **State** _____**Zip** _____

Home Phone _____ **Cell Phone** _____

Employer_____

Employer Address _____

City _____ **State** _____**Zip** _____

Occupation _____

Work Phone _____

In Case of Emergency Contact:

Name _____

Relationship _____

Phone Number _____

Whom may we thank for referring you to us? _____

I UNDERSTAND THAT I AM FULLY FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE

Signature: _____ Date: _____

MEDICATIONS

List medications you are currently taking :

_____

_____

_____

Pharmacy _____ Phone _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other (please list)

_____

CHECK ANY SYMPTOM(S) OR CONDITION(S) BELOW THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR:

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arm Pain or Numbness
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain or Numbness
- ☐ Bleeding Disorders
- ☐ Bleeding Gums
- ☐ Bloating
- ☐ Blood in Urine
- ☐ Blurred Vision
- ☐ Bowel Changes
- ☐ Breast Lump
- ☐ Bright Disease
- ☐ Bruise Easily
- ☐ Bursitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Change in Moles
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Chicken Pox
- ☐ Chills
- ☐ Constipation
- ☐ Crossed Eyes
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Depression/Nervousness
- ☐ Difficulty Swallowing
- ☐ Dizziness Fainting
- ☐ Double Vision
- ☐ Excessive Thirst
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Earache
- ☐ Ear Discharge
- ☐ Feet Pain or Numbness
- ☐ Fever
- ☐ Forgetfulness
- ☐ Frequent Urination
- ☐ Gas
- ☐ Glaucoma
- ☐ Hand Pain or Numbness
- ☐ Hay Fever
- ☐ Headache
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hip Pain or Numbness
- ☐ HIV Positive
- ☐ Hives
- ☐ Hoarseness
- ☐ Indigestion
- ☐ Irregular Heartbeat
- ☐ Itching
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Lack of Bladder Control
- ☐ Leg Pain or Numbness
- ☐ Liver Disease
- ☐ Loss of Hearing
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Low Blood Pressure
- ☐ Lumbago
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Nausea
- ☐ Neck Pain or Numbness
- ☐ Neuralgia
- ☐ Neuritis
- ☐ Nose Bleeds
- ☐ Pacemaker
- ☐ Painful Urination
- ☐ Persistent Cough
- ☐ Pneumonia
- ☐ Polio
- ☐ Poor Appetite
- ☐ Poor Circulation
- ☐ Prostate Problem
- ☐ Rapid Heartbeat
- ☐ Rash
- ☐ Rectal Bleeding
- ☐ Rheumatic Fever
- ☐ Ringing in Ears
- ☐ Scarlet Fever
- ☐ Scars
- ☐ Sciatica
- ☐ Shoulder Pain or Numbness
- ☐ Sinus Problems
- ☐ Sore That Won't Heal
- ☐ Stomach Aches or Pains
- ☐ Stroke
- ☐ Sweats
- ☐ Swelling Ankles
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Vision Flashes
- ☐ Vomiting
- ☐ Vomiting Blood

CHECK DEGREE OF HABITS BELOW. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

	HEAVY	CASUAL	LIGHT	NONE		HEAVY	CASUAL	LIGHT	NONE		HEAVY	CASUAL	LIGHT	NONE
Alcohol	☐	☐	☐	☐	Drugs	☐	☐	☐	☐	Soft Drinks	☐	☐	☐	☐
Appetite	☐	☐	☐	☐	Exercise	☐	☐	☐	☐	Sugar/Sugar Products	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐	Salty Foods	☐	☐	☐	☐	Tobacco	☐	☐	☐	☐
Coffee	☐	☐	☐	☐	Sleep	☐	☐	☐	☐	Water	☐	☐	☐	☐

I certify that the above information is correct to the best of my knowledge. I will not hold my dentist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form

Signature: _____ Date: _____