

18 East 50th Street, Suite 11B
New York, NY 10022

Rita Taliwal D.M.D., M.S.

45-45 21st Street
Long Island City, NY 11101

Patient Acquaintance Form

Patient Name: _____ Address: _____

City/State/Zip _____ Birthdate: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Sex (M/F): _____ Marital Status: _____ Email Address: _____

Name Of Responsible Party: _____ Billing Address: _____

Dental Insurance Company: _____ Subscriber's Name: _____

Subscriber's SS#: _____ Subscriber's Birthdate: _____ Employer: _____

General Dentist Name: _____ General Dentist Phone #: _____

Referred By: _____ Have You Seen An Orthodontist Before?: Yes ___ No ___

How Would You Like Your Appointment Reminders?:

___ Text - Please Provide Cell Phone Carrier: _____
___ Email

Does Your Medical History Include Any of the Following:	Yes	No
Allergies to Anesthetics	___	___
Allergies to any Medications	___	___
Any Heart Ailments/Heart Murmur	___	___
Rheumatic Fever	___	___
High Or Low Blood Pressure	___	___
Neurological Disorders	___	___
Radiation Treatment	___	___
Excessive Bleeding From Cut Or Extraction	___	___
Anemia Or Blood Problems	___	___
Arthritis	___	___
Asthma	___	___
Osteoporosis	___	___
Hay Fever Or Allergies In General	___	___
Diabetes /Kidney Problems	___	___
Liver Problems or Hepatitis	___	___
Malignancies	___	___
Psychiatric Care	___	___
Sinus Problems	___	___
Stroke	___	___
Thyroid	___	___
Eye Disorder	___	___
Tonsillitis	___	___
Tuberculosis	___	___
Ulcer Or Colitis	___	___
Pregnancy- If So What Month _____	___	___
Venereal Disease	___	___
Acquired Immune Deficiency Syndrome (AIDS)	___	___
Any Other Medical Conditions _____	___	___

List Any Drugs or Medications You are Currently Taking: _____

In Case Of Emergency, Notify: _____ Phone #: _____

Patient/Responsible Party's Signature: _____ Today's Date: _____