**Rita Taliwal D.M.D., M.S.**
**18 East 50th Street, Suite 11B**
**New York NY 10022**

# 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** | ____ | ____ |
| **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:_______________**