CONFIDENTIAL PATIENT INFORMATION

Family Dentistry of New Jersey

PATIENT INFORMATION

Last Name: _____

First Name: _____

Title (circle one) Dr. Mr. Mrs. Miss. Ms.

Social Security #: - -

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Cell Phone: _____

Email Address: _____

Birthdate: _____ Age: _____ Sex: ☐ M ☐ F

Patient Employer: _____

Patient Occupation: _____

Employer Address: _____

Spouse Name: _____

Birthdate: _____ SS#: _____

Spouse's Employer: _____

How did you hear about our office? _____

EMERGENCY CONTACT

Name: _____ Phone# _____

Relationship: _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Co. _____ Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# - -

Relationship to Patient _____

Insurance Co. _____ Group # _____

FINANCIAL INFORMATION

For your convenience we accept Visa, MasterCard, Discover and Debit Cards. We deliver the finest care at a reasonable cost to our patients, therefore **payment is due at the time service is rendered** unless other arrangements have been made in advance. We will work with you to maximize your insurance reimbursement for covered procedures. Please present your insurance information at your first visit so that we can expedite reimbursement.

X _____

Signature of Patient, Parent, Guardian, or Personal Representative

_____

Please Print Name

Date: _____ Relationship to Patient: _____

DENTAL HISTORY

Reason For Today's Visit: _____

Previous Dentist/s: _____

City/State: _____

Date of last dental visit: _____

Date of last dental x-rays: _____

Please circle if you have or have had any of the following:

Bad Breath
Bleeding gums
Blisters on lips or mouth
Burning sensation on tongue or mouth
Chew on one side of mouth
Cigarette, pipe, or cigar smoking
Cleft lip or palate
Clicking or popping of jaw
Dry mouth
Fingernail biting
Food collection between teeth
Grinding/clenching teeth
Gum Recession
Gums swollen or tender
Implant Surgery
Jaw pain or tiredness
Lip or cheek biting
Loose teeth or broken fillings
Mouth breathing/Mouth Odor
Mouth pain when brushing
Orthodontic treatment (Braces)
Pain around ear
Periodontal treatment/surgery
Removable or fixed prosthesis/dentures/partials
Sensitivity to cold, hot, or sweet
Sensitivity when biting
Sores, swelling, or growths in your mouth
TMJ problems/pain/popping/locking

How often do you brush? _____

How often do you floss? _____

Have you ever whitened your teeth? _____

What changes in your smile would you make, if any? _____

_____

FOR OFFICE USE ONLY

ASA CATEGORY: 1 2 3 4 JMC JAZ NOTE:

MEDICAL HISTORY

Physicians Name:_____City:_____Date of Last visit:_____

In your estimation, what is your general health condition ❑ **Excellent,** ❑ **Good,** ❑ **Fair,** ❑ **Poor**

Please circle if you have or have had any of the following conditions or ✓ Negative:

Cardiovascular (Heart) ❑ **Negative**
Chest pain (Angina)
Congenital heart problem
Heart attack
Heart murmur
Heart surgery: bypass, transplant, stents
Heart valve repair
High blood pressure (hypertension)
Irregular heartbeat(arrhythmia)
I take aspirin regularly
Mitral Valve Prolapse
Pacemaker
Prosthetic/artificial heart valve
Congestive Heart Failure (CHF)

Pulmonary (Lung) ❑ **Negative**
Asthma
Emphysema, bronchitis
Pneumonia
Tuberculosis (TB)
PPD Positive
Persistent Cough
Respiratory Disease
Shortness of Breath
Chronic Pulmonary Disease (CPD)

Nervous System ❑ **Negative**
Alzheimer's disease or other dementia (schizophrenia)
Degenerative disorders or paralysis, (Parkinson's, MS, cerebral palsy, muscular dystrophy, bells palsy)
Depression, phobias
Severe anxiety disorder
Fainting/dizziness
Headaches, frequent or severe
Psychiatric care, nervous conditions
Seizures/epilepsy
Sleep Apnea ❑ **Obstructive** ❑ **Central**
Stroke (CVA)

Hematologic (Blood) ❑ **Negative**
Anemia (not sickle cell)
Bleeding disorder (not hemophilia), post surgical
Blood transfusion
Bone marrow or stem cell transplant
Bruises easily (INR >3.5)
Leukemia, blood cancer, lymphoma, multiple myeloma
Sickle cell anemia/trait blood disorder

Gastrointestinal (Digestive) ❑ **Negative**
Cirrhosis
Crohn's or ulcerative colitis
Eating disorders (bulimia, anorexia)
Heart burn, reflux/GERD
Hepatitis Type _____
Irritable bowl syndrome
Jaundice
Liver Disease
Transplant: liver, kidney or other
Ulcer (s)

Genitourinary (***Kidneys, urinary***) ❑ **Negative**
Dialysis
Kidney disease or failure
Syphilis, gonorrhea, herpes
Venereal Disease
Other _____

Endocrine ❑ **Negative**
Adrenal disorder
Diabetes(HbA1c=____) ❑ **Type I** ❑ **Type II**
Prostate problem
Thyroid ❑ **Hyper** ❑ **Hypo**

Cancer ❑ **Negative**
Any history of cancer (breast, head, neck, prostate, oral, lung, skin, etc.)
Chemotherapy treatment _____
Radiation treatment _____

Musculoskeletal ❑ **Negative**
Artificial joint(s)
Degenerative Osteo arthritis
Neck or back surgery/ pain
Osteoporosis/Osteopenia
Bisphosphonate Use (Fosamax, Boniva, Actonel, or Injectable)
Rheumatoid arthritis
Sinus problems
Swollen neck glands
Weight loss, unexplained
Xerostomia/dry mouth
Swollen ankles

Immune System ❑ **Negative**
Allergy to Anesthetics
Allergy to foods, metals, jewelry
Allergy to latex
Allergy to medications:_____
_____
HIV or AIDS
Lupus
Sjogren's syndrome
Rash, hives, sores
Cortisone Treatments

Surgery ? _____

Drug Use ❑ **Negative**
Alcohol dependency
Chemical dependency
Prior or current injection drug use
Prior or current non-injection recreational drug use
Tobacco Use

Women ❑ **Negative**
I am pregnant or possibly pregnant
I am nursing
Post-menopause
Oral contraceptive
Other illness:_____

History of Hospitalization? _____

Is there anything else we should know about your medical history?_____

Please list all medications you are currently taking _____

The above medical history has been reviewed with me and the recordings are complete and accurate.
I will not hold any dentist or any member of his/her staff responsible of any errors or omissions that I have made in the completion of this form.

Patient signature ✗ _____ Date: _____