

Patient Information

Welcome! Thank you for choosing our practice for your dental needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Home Phone # _____ Work Phone # _____

Social Security # _____ Cell Phone # _____ Beeper # _____

Email Address _____

Employer _____ Occupation _____

Spouse's or Parent's Name _____ Work Phone # _____

If you are a student, name of school/college _____ City _____ State _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Responsible Party

Person responsible for this account _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone # _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone # _____

Address _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____ Employer # _____

Insurance Company Address _____ City _____ State _____ Zip _____

DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone # _____

Address _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____ Employer # _____

Insurance Company Address _____ City _____ State _____ Zip _____

Dental History

Name _____ Age _____

Reason for today's visit _____

Date of last exam _____ Date of last dental x-rays _____

How often do you brush _____ How often do you floss _____

Please check any of the following conditions that apply to you:

- | | | |
|---|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Previous periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Previous orthodontic treatment | | |

Medical History

Physician _____ Physician's Phone # _____

Please list all the medications you are currently taking (including aspirin) _____

Are you allergic to any medications _____

(Women) Are you pregnant? No Yes Nursing? No Yes Taking birth control pills? No Yes

Do you have a history of the following?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swelling of feet or Ankles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer | |
| <input type="checkbox"/> Other (describe) | | | |

Method of Payment

Please check the method of payment: Cash Check MC Visa

Note: Payment is due at time of service. If you have dental insurance, deductibles and co-payment are due at time of treatment. A major credit card will be kept on file for your convenience.

_____ Exp. Date _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any balance not paid for by your insurance. If we have agreed to wait for said insurance monies and reimbursement is short of what is expected then your credit card will be billed and you will be promptly notified. Your cooperation in this matter helps to control our costs.

Authorization

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of the patients record and any information necessary. I hereby assign all major medical and/or dental benefits to New Jersey Dental Arts. This assignment and that for credit card billing will remain in effect until revoked by me in writing. A photocopy of this assignment and authorization is considered to be valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. The information on this page and the medical history are correct to the best of my knowledge.

Signed _____ Date _____
Responsible Party _____ Date _____