



Adult

Welcome to our office. We appreciate the confidence you place with us to provide your dental care. To assist us in serving you, please complete the following forms. The information provided on this form is important to your dental health. If you have any questions please do not hesitate to ask. Please fill out the forms and print. Please fax to 973-635-6910, mail or bring your completed forms with you. Please do not email the forms back.

PATIENT INFORMATION . . .

Mr. Mrs. Ms. Dr. First Name M.I. Last Name Nickname
Sex: Male Female Birth Date Soc. Sec. # E-mail
Street Apt. City State Zip
Cell ( ) Home ( )
Employer Work ( )
Please indicate preferred method of contact. E-mail Text Cell Home Work Mail (Number in order of preference)
Referred By
Previous Dentist Medical Doctor
In case of emergency, please contact Tel. ( ) Relation

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT . . .

Self (If self, skip this section) Spouse Other
First Name Last Name Soc. Sec. # Birth Date
Tel. ( )
Street Apt. City State Zip
Employer Work ( )

PRIMARY DENTAL INSURANCE COMPANY . . .

Group # Group Name
Employer Insured Party Relation
Bus. Address Sex: M F Birth Date Soc. Sec. #
Bus. Tel. ( ) Plan Street City
Ins Co. Name I.D.# State/Zip Tel. ( )
Address Tel. ( )

DENTAL INFORMATION . . .

Are you satisfied with your past dentistry? If no, what were you not satisfied with.
How many times a day do you brush your teeth?
Is your brush sensitive? soft medium hard
Do you use a Sonicare toothbrush?
How many times a week do you floss your teeth?
Do your gums bleed when you brush or floss?
Are your teeth sensitive to hot, cold or sweets?
How long have you been experiencing pain or discomfort?
Please rate the pain a scale of 1-10 with 10 being the worst.
Do you have any broken teeth?
Do you have any lost or broken fillings?
Have you had any periodontal (gum) surgery?
Have you ever had any root canals?
Is your home water supply fluoridated?
Do you grind or clench your teeth?
Have you noticed any wear on the edges of your teeth?
Do you have any pain when opening or closing?
Do you have any earaches or ringing in your ears?
Do you have any neck pain?
Do you suffer from frequent headaches?
Do you have clicking, popping or discomfort in your jaw?
Has your jaw ever locked open or closed?
Are you under excess stress?
Do any of your teeth feel loose?
Do you wear a night guard?
Have you ever had your bite adjusted?
Do you have frequent sores or ulcers in your mouth?
Do you get cold sores on your lips?
Do you wear dentures or partials?
Have you had any tooth implants?
Do you participate in any contact sports activities?
Do you wear a mouth guard?
Have you ever had a serious injury to your head, mouth or jaw?
Have you had your wisdom teeth extracted?
Have you ever had prolonged bleeding after an extraction?
Does food get caught between your teeth?
Do you have trouble with bad breath?
Do you have any swelling or lumps in your mouth?
Do you have sleep apnea?
Have you ever done a sleep study for sleep apnea?
Do you wear an appliance for sleep apnea dental appliance?
Do you use C-pap machine?
Do you experience anxiety with dental treatment?
Have you ever had a bad dental experience?
Have you had orthodontic treatment?
Do you still wear a retainer?
Have you noticed any changes in your tooth positions?
Would you like your teeth to be straighter?
Have you ever bleached your teeth?
Were you happy with the results?
Would you like your teeth whiter?
Please rate your smile on a scale of 1-10. (10 being the best)
Is there anything you would like to change about the appearance of your smile?

**MEDICAL INFORMATION . . .**

**(Check DK if you Don't Know the answer to the question)**    **Yes**    **No**    **DK**

Do you wear contact lenses?.....        

**Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?.....           
 Date:\_\_\_\_\_ If yes, have you had any complications?

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?.....        

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?.....           
 Date Treatment began:\_\_\_\_\_

**Allergies** - Are you allergic to or have you had a reaction to: **Yes**    **No**    **DK**  
 To all **yes** responses, specify type of reaction.

- Local anesthetics \_\_\_\_\_
- Aspirin \_\_\_\_\_
- Penicillin or other antibiotics \_\_\_\_\_
- Sulfa drugs \_\_\_\_\_
- Codeine or other narcotics \_\_\_\_\_
- Metals \_\_\_\_\_

List any medications you are taking.

\_\_\_\_\_

\_\_\_\_\_ **Yes**    **No**    **DK**

Do you use controlled substances (drugs)?.....        

Do you use tobacco (smoking, snuff, chew, bidis)? .....        

If so, how interested are you in stopping?  
 (Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages?.....        

If yes, how much do you typically drink in a week? \_\_\_\_\_

**WOMEN ONLY** Are you:

Pregnant?.....        

Number of weeks: \_\_\_\_\_

Taking birth control pills or hormonal replacement?....        

Nursing?.....        

\_\_\_\_\_ **Yes**    **No**    **DK**

Latex (rubber)\_\_\_\_\_        

Iodine \_\_\_\_\_        

Hay fever/seasonal \_\_\_\_\_        

Food \_\_\_\_\_        

Other \_\_\_\_\_        

**MEDICAL HISTORY**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Acid reflux/Gerds          | <input type="checkbox"/> <input type="checkbox"/> Congenital heart disorders | <input type="checkbox"/> <input type="checkbox"/> Heart trouble/disease | <input type="checkbox"/> <input type="checkbox"/> Radiation treatment        |
| <input type="checkbox"/> <input type="checkbox"/> Aids/ HIV positive         | <input type="checkbox"/> <input type="checkbox"/> Convulsion                 | <input type="checkbox"/> <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> <input type="checkbox"/> Recent weight loss         |
| <input type="checkbox"/> <input type="checkbox"/> Alzheimer's disease        | <input type="checkbox"/> <input type="checkbox"/> Contagious disease         | <input type="checkbox"/> <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> <input type="checkbox"/> Renal dialysis             |
| <input type="checkbox"/> <input type="checkbox"/> Autoimmune disease         | <input type="checkbox"/> <input type="checkbox"/> Cortisone medicine         | <input type="checkbox"/> <input type="checkbox"/> Hepatitis B/C         | <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever            |
| <input type="checkbox"/> <input type="checkbox"/> Anaphylaxis                | <input type="checkbox"/> <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> <input type="checkbox"/> Herpes                | <input type="checkbox"/> <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> <input type="checkbox"/> Anemia                     | <input type="checkbox"/> <input type="checkbox"/> Drug addiction             | <input type="checkbox"/> <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> <input type="checkbox"/> Scarlet fever              |
| <input type="checkbox"/> <input type="checkbox"/> Angina                     | <input type="checkbox"/> <input type="checkbox"/> Easily winded              | <input type="checkbox"/> <input type="checkbox"/> Hives/rash            | <input type="checkbox"/> <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis/Gout             | <input type="checkbox"/> <input type="checkbox"/> Eating disorders           | <input type="checkbox"/> <input type="checkbox"/> HPV                   | <input type="checkbox"/> <input type="checkbox"/> Sickle cell disease        |
| <input type="checkbox"/> <input type="checkbox"/> Artificial heart valve     | <input type="checkbox"/> <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> <input type="checkbox"/> Hyperglycemia         | <input type="checkbox"/> <input type="checkbox"/> Sinus trouble              |
| <input type="checkbox"/> <input type="checkbox"/> Artificial joint           | <input type="checkbox"/> <input type="checkbox"/> Epilepsy/seizures          | <input type="checkbox"/> <input type="checkbox"/> Irregular heartbeat   | <input type="checkbox"/> <input type="checkbox"/> Spina bifida               |
| <input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis           | <input type="checkbox"/> <input type="checkbox"/> Excessive bleeding         | <input type="checkbox"/> <input type="checkbox"/> Kidney problems       | <input type="checkbox"/> <input type="checkbox"/> Stomach/intestinal disease |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                     | <input type="checkbox"/> <input type="checkbox"/> Excessive thirst           | <input type="checkbox"/> <input type="checkbox"/> Leukemia              | <input type="checkbox"/> <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> <input type="checkbox"/> Blood disease              | <input type="checkbox"/> <input type="checkbox"/> Fainting spells/dizziness  | <input type="checkbox"/> <input type="checkbox"/> Liver disease         | <input type="checkbox"/> <input type="checkbox"/> Swelling of limbs          |
| <input type="checkbox"/> <input type="checkbox"/> Blood transfusion          | <input type="checkbox"/> <input type="checkbox"/> Frequent cough             | <input type="checkbox"/> <input type="checkbox"/> Low blood pressure    | <input type="checkbox"/> <input type="checkbox"/> Thyroid disease            |
| <input type="checkbox"/> <input type="checkbox"/> Breathing problem          | <input type="checkbox"/> <input type="checkbox"/> Frequent diarrhea          | <input type="checkbox"/> <input type="checkbox"/> Lupus                 | <input type="checkbox"/> <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> <input type="checkbox"/> Bruise easily              | <input type="checkbox"/> <input type="checkbox"/> Frequent headaches         | <input type="checkbox"/> <input type="checkbox"/> Lung disease /COPD    | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> <input type="checkbox"/> Cancer                     | <input type="checkbox"/> <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> <input type="checkbox"/> Lymes disease         | <input type="checkbox"/> <input type="checkbox"/> Tumors                     |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy               | <input type="checkbox"/> <input type="checkbox"/> Hay fever                  | <input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> <input type="checkbox"/> Chest pains                | <input type="checkbox"/> <input type="checkbox"/> Heart attack/failure       | <input type="checkbox"/> <input type="checkbox"/> Pain in jaw or joints | <input type="checkbox"/> <input type="checkbox"/> Venereal disease           |
| <input type="checkbox"/> <input type="checkbox"/> Chronic fatigue syndrome   | <input type="checkbox"/> <input type="checkbox"/> Heart murmur               | <input type="checkbox"/> <input type="checkbox"/> Parathyroid disease   | <input type="checkbox"/> <input type="checkbox"/> Yellow jaundice            |
| <input type="checkbox"/> <input type="checkbox"/> Cold sores/ fever blisters | <input type="checkbox"/> <input type="checkbox"/> Heart pacemaker            | <input type="checkbox"/> <input type="checkbox"/> Psychiatric care      |  |

Have you had any serious illness not listed above? If yes please explain: \_\_\_\_\_

To the best of my knowledge all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous. I ever have any change in my health or change in my medication I will inform the dentist, hygienist or the dental office.

\_\_\_\_\_/\_\_\_\_\_  
 Signature of patient or legal guardian    Date

\_\_\_\_\_  
 Dentist signature/Date

\_\_\_\_\_  
 Relationship to patient

\_\_\_\_\_  
 Dental hygienist/ Date

**Fees and payments:**

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Arrangements can be made depending upon special circumstances. An estimate of the charge for any procedure will be given to you upon your request. If you have any dental insurance we will be glad to fill out the proper forms and submit the claim. 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. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

X \_\_\_\_\_ X \_\_\_\_\_  
 Signature of patient    Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to the doctor named of the benefits otherwise payable to me.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X \_\_\_\_\_/\_\_\_\_\_  
 Signature of patient    Date

X \_\_\_\_\_/\_\_\_\_\_  
 Signature of patient    Date