Dental Health Providers of New Jersey PC

Patient Information

Patient's Name: Last_____ First_____ M.I._____ Sex: M F Birth date __/__/____ Age____
Soc. Sec. #_____-____-_____ If patient is a minor, Parent's or Guardian's Name_____ Date____/____/_____
Who May we thank for referring you to our Office? _____ Reason for this Visit_____

Responsible Party Information

Name: _____ ‖ Married ‖ Single ‖ Minor ‖ Divorced ‖ Widowed ‖ Other
Last First Middle
Residence Street _____ Apt#_____ City _____ State _____ Zip_____
Mailing Address Street _____Apt # _____City _____ State _____ Zip_____
Home Phone (____)_____-_____ Cell Phone (____)_____-_____ Work Phone (____)_____-_____
Social Security # _____-____-_____ Birth Date _______________ Driver's License#_____
Relationship to patient_____ Employer _____ Occupation_____

Responsible Party's Spouse

Name _____
Last First Middle
Employer _____Occupation_____
Soc. Sec.# _____ Birth date ____/____/_____
Home (____)_____-_____ Cell (____)_____-_____
Work (_____) _____-_____
Email _____

Emergency Information

Name _____
Last First Middle
Address _____ City_____
State_____ Zip_____
Relationship to patient_____
Home (____)_____-_____ Cell (____)_____-_____

Primary Dental Insurance Information

Subscriber's Name _____
Insurance Company _____
Subscriber's employer _____
ID#_____ Group #_____
Relationship to patient _____

Secondary Dental Insurance Information

Subscriber's Name _____
Insurance Company _____
Subscriber's employer _____
ID#_____ Group #_____
Relationship to patient _____

It is important that I know about your medical and dental history. These facts have a direct bearing on your dental Health. This Information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
How long since you have seen a dentist?		
When was your last set of x-rays taken?		
Do you have good oral health?	╗	╗
Are you apprehensive about dental treatment?	╗	╗
Have you had any periodontal (gum) treatments?	╗	╗
Do your gums bleed, feel tender or feel irritated?	╗	╗
Are your teeth sensitive to hot, cold, sweets, pressure? (Circle)	╗	╗
Do you have HEADACHES, EARACHES, or NECK PAINS?	╗	╗
Are you aware of GRINDING or CLENCHING your teeth?	╗	╗
Are you HAPPY with the APPEARANCE of your teeth?	╗	╗
Have you worn BRACES on your teeth? (ORTHODONTICS)	╗	╗
Do you REGULARLY use DENTAL FLOSS?	╗	╗
Is there any other Dental or Medical information that you feel we should know about?		
Have you had any Surgeries? (Specify &Date)		
Family Physician_____ Phone(____)_____		

PATIENT Signature (or Responsible Party) :
_____
Date:
_____

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	╗	╗
Are you under a PHYSICIAN'S CARE now?	╗	╗
For what?		
What MEDICATIONS are you currently taking?		
Do you have any allergies to Medications? If so please list:		
Are you PREGNANT?	╗	╗
Do you use cigars/cigarettes, pipe or chew tobacco? (Circle)	╗	╗

Check all that applies:

- ╗ AIDS/HIV
- ╗ Anaphylaxis
- ╗ Anemia
- ╗ Arthritis
- ╗ Artificial heart Valve
- ╗ Artificial joints
- ╗ Asthma
- ╗ Atopic
- ╗ Back Problems
- ╗ Blood disease
- ╗ Cancer
- ╗ Chemical dependency
- ╗ Chemotherapy
- ╗ Circulatory problems
- ╗ Cortisone treatments
- ╗ Cough up blood
- ╗ Diabetes
- ╗ Epilepsy/Seizures
- ╗ Fainting
- ╗ Food Allergies
- ╗ Glaucoma
- ╗ Headaches
- ╗ Heart Murmur
- ╗ Heart Disease
- ╗ Hemophilia
- ╗ Herpes
- ╗ Hepatitis
- ╗ High Blood Pressure
- ╗ Jaw Pain
- ╗ Kidney disease
- ╗ Liver disease
- ╗ Material Allergies
  - chemicals
  - latex
  - Metal Allergy
  - wool
- ╗ Mitral Valve Prolapse
- ╗ Nervous Problems
- ╗ Pacemaker/heart surgery
- ╗ Psychiatric care
- ╗ Rapid weight gain/loss
- ╗ Radiation Treatment
- ╗ Rheumatic/scarlet fever
- ╗ Shingles
- ╗ Shortness of breath
- ╗ Skin Rash
- ╗ Stroke
- ╗ Surgical Implant
- ╗ Swelling of feet / ankles
- ╗ Thyroid Disease
- ╗ Tuberculosis
- ╗ Ulcer/Colitis
- ╗ Venereal disease