CONFIDENTIAL PATIENT INFORMATION

Specialized 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.

____
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 bowel 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: __________