PATIENT INFORMATION – GENERAL:

NAME: ____ DATE: ______________________
FIRST MI LAST

ADDRESS: ____________________________ CITY: _______________ STATE: __________ ZIP:________

DATE OF BIRTH (MM/DD/YYYY): _________________________ SOCIAL SECURITY #: ______________________

PRIMARY PHONE #: ________________ CELL ☐ HOME ☐ E-MAIL: ____________________________

SECONDARY PHONE #: _______________ CELL ☐ HOME ☐ DRIVER'S LICENSE #: ______________________

CHECK APPROPRIATE BOX: MINOR - ☐ SINGLE - ☐ MARRIED - ☐ DIVORCED - ☐ WIDOWED - ☐ SEPARATED - ☐

WHOM MAY WE THANK FOR REFERRING YOU? ____

EMERGENCY CONTACT:

NAME: ____ PHONE #: _________________
FIRST LAST

RESPONSIBLE PARTY:

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: ____

*****IF PERSON RESPONSIBLE FOR THIS ACCOUNT IS THE PATIENT, AND ALL OF THE INFORMATION IS THE SAME AS ABOVE, PLEASE CHECK THIS BOX AND CONTINUE TO THE 'INSURANCE' SECTION OF THIS FORM:** ☐

RELATIONSHIP TO PATIENT: ________________ ADDRESS: ______________________________________

PRIMARY PHONE #: ____________________ DRIVER'S LICENSE #: ___________________ STATE: ________

DOB (MM/DD/YYYY)____________________ SOCIAL SECURITY #: ________________________________

EMPLOYER: ______________________________ WORK PHONE #: ______________________________

IS THIS PERSON CURRENTLY A PATIENT AT OUR OFFICE? YES - ☐ NO - ☐

PRIMARY DENTAL INSURANCE INFORMATION:

NAME OF INSURED: ________________________________ RELATIONSHIP TO PATIENT: ___________________

DOB (MM/DD/YYYY): _______________________________ SOCIAL SECURITY #: _______________________

NAME OF EMPLOYER: ______________________________ DATE EMPLOYED: __________________________

UNION OR LOCAL #: __________________________ WORK PHONE #: _____________________________

EMPLOYER ADDRESS: _________________________ CITY:______________ STATE:____________ ZIP:______

INSURANCE COMPANY: ______________________POLICY/ID #: ____________________ GROUP #: ____________

INSURANCE COMPANY ADDRESS: ____________________________INSURANCE COMPANY PHONE #: ____________

SECONDARY DENTAL INSURANCE INFORMATION *(IF APPLICABLE)*:

NAME OF INSURED: ________________________________ RELATIONSHIP TO PATIENT: ___________________

DOB (MM/DD/YYYY): _______________________________ SOCIAL SECURITY #: _______________________

NAME OF EMPLOYER: ______________________________ DATE EMPLOYED: __________________________

UNION OR LOCAL #: __________________________ WORK PHONE #: _____________________________

EMPLOYER ADDRESS: _________________________ CITY:______________ STATE:____________ ZIP:______

INSURANCE COMPANY: ______________________POLICY/ID #: ____________________ GROUP #: ____________

INSURANCE COMPANY ADDRESS: ____________________________INSURANCE COMPANY PHONE #: ____________

X ____ DATE:____________________
SIGNATURE OF PATIENT OR GUARDIAN IF MINOR

PATIENT MEDICAL HISTORY

PATIENT'S NAME:______________________________EMAIL:___________________________DATE OF BIRTH:___________

**ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

1. ARE YOU IN GOOD HEALTH…………………… YES NO
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR… YES NO
3. DATE OF YOUR LAST PHYSICAL EXAM________________
4. PHYSICIAN'S NAME ______________________________
   ADDRESS____________________________________
   PHONE NO. __________________________________
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN……………………………………………….. YES NO
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS……………………………………………… YES NO
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE ………………………………………… YES NO
   IF YES, WHAT MEDICATION(S)…
   ____
8. HAVE YOU HAD ANY ABNORMAL BLEEDING ………………………………………… YES NO
9. DO YOU BRUISE EASILY ……………………… YES NO
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION …………………………………… YES NO
11. HAVE YOU HAD A RECENT WEIGHT LOSS _____ _____
12. HAVE YOU EVER TAKEN FEN-PHEN OR REDUX………………………………………………. YES NO
13. DO YOU USE TOBACCO ……………………… YES NO
14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES ……………… YES NO
15. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT… YES NO

WOMEN ONLY:

16. ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT ………………………….. YES NO
17. ARE YOU NURSING …………………………. YES NO
18. ARE YOU TAKING BIRTH CONTROL PILLS YES NO

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

LOCAL ANESTHETICS LIKE NOVOCAINE……………….. YES NO
PENICILLIN OR OTHER ANTIBIOTICS……………………. YES NO
SULFA DRUGS……………………………………………………. YES NO
BARBITURATES, SEDATIVES OR SLEEPING PILLS……………………………………………………………………. YES NO
ASPIRIN……………………………………………………………. YES NO
ANY METALS (E.G., NICKEL, MERCURY, ETC.) ………. YES NO
LATEX / RUBBER ……………………………………………….. YES NO
Others (PLEASE LIST)
____

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING?

DIABETES: YES NO
RHEUMATIC FEVER: YES NO
SCARLET FEVER: YES NO
HEART DEFFECT: YES NO
HEART MURMUR: YES NO
HEART TROUBLE: YES NO
HEART ATTACK: YES NO
EPILEPSY OR SEIZURES: YES NO
MENTAL HEALTH CARE: YES NO
PACEMAKER: YES NO
HEART SURGERY: YES NO
LIVER DISEASE: YES NO
HEPATITIS: YES NO
JAUNDICE: YES NO
COLD SORES: YES NO

HYPOGLYCEMIA: YES NO
THYROID PROBLEMS: YES NO
ALLERGIES: YES NO
JOINT REPLACEMENT: YES NO
KIDNEY TROUBLE: YES NO
TUBERCULOSIS: YES NO
TUMORS: YES NO
ANGINA: YES NO
STROKE: YES NO
CHEST PAIN: YES NO
SINUS TROUBLE: YES NO
FEVER BLISTERS: YES NO

SHORTNESS OF BREATH: YES NO
CONGENITAL HEART PROBLEM: YES NO
HIGH/LOW BLOOD PRESSURE: YES NO
EATING DISORDERS: YES NO
SEXUALLY TRANSMITTED DISEASE: YES NO
ASTHMA OR HAY FEVER: YES NO
CHEMICAL DEPENDENCY: YES NO
AIDS OR HIV INFECTION: YES NO
CORTISONE TREATMENT: YES NO
CHEMOTHERAPY(CANCER/LEUKEMIA): YES NO

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT FOR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHROIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR MY SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X____DATE_________

SIGNITURE OF PATIENT OR PARENT/GUARDIAN OF A MINOR

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

> While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

Signature: **Date of visit:**

Patient/Responsible Party

PLEASE ANSWER "YES" OR "NO" WITH YOUR **INITIALS** TO THE FOLLOWING QUESTIONS:

HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME? ________ **YES** ________ **NO**

IF YES, WHEN:______________________

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? ________ **YES** ________ **NO**

DO YOU HAVE A FEVER? ________ **YES** ________ **NO**

DO YOU HAVE ANY SHORTNESS OF BREATH? ________ **YES** ________ **NO**

DO YOU HAVE A DRY COUGH? ________ **YES** ________ **NO**

DO YOU HAVE A RUNNY NOSE? ________ **YES** ________ **NO**

DO YOU HAVE A SORE THROAT? ________ **YES** ________ **NO**

DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES? ________ **YES** ________ **NO**

HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS? ________ **YES** ________ **NO**

HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL? ________ **YES** ________ **NO**

WITHIN THE LAST 10 DAYS, HAVE YOU TRAVELLED OUTSIDE NEW JERSEY, NEW YORK, CONNECTICUT, PENNSYLVANIA OR DELAWARE? ________ **YES** ________ **NO**

IF YES, HAVE YOU BEEN FULLY VACCINATED FOR MORE THAN 2 WEEKS? ________ **YES** **NO**