PATIENT INFORMATION

Name:_____ Birthdate:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Emergency Contact Name:_____ Phone #:_____

INSURANCE INFORMATION

Dental Insurance Carrier:_____ Subscriber's SS or Insurance ID:_____
Subscriber's Name:_____ Birthdate:_____

Secondary Insurance Carrier:_____ Subscriber's SS or Insurance ID:_____
Subscriber's Name:_____ Birthdate:_____

MEDICAL HISTORY

Physician:_____ Office Phone:_____ Date of exam:_____

	Yes	No
1. Are you under medical treatment now?	□	□
2. Have you been hospitalized for any reason in the last 5 years? If yes, please explain_____	□	□
3. Are you taking any medication(s) including non-prescription medicine? If yes, please list_____	□	□
4. Have you ever taken Fen-Phen/Redux?	□	□
5. Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates?	□	□
6. Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?	□	□
7. Do you use tobacco?	□	□
8. Do you use controlled substances?	□	□

	Yes	No
9. Are you wearing contacts?	□	□
10. Are you allergic to ANY of the following?		
Local Anesthetics	□	□
Penicillin or Antibiotics	□	□
Sulfa Drugs	□	□
Barbiturates	□	□
Sedatives	□	□
Iodine	□	□
Aspirin	□	□
Any Metals	□	□
Latex Rubber	□	□
Other?	□	□
11. Women only:		
a. Are you or think you may be pregnant?	□	□
b. Are you nursing?	□	□
c. Are you taking birth control?	□	□

Do you have any of the following?	Yes	No
High Blood pressure	□	□
Heart Attack	□	□
Rheumatic Fever	□	□
Swollen Ankles	□	□
Fainting/Seizures	□	□
Asthma	□	□
Low Blood Pressure	□	□
Epilepsy/Convulsions	□	□
Leukemia	□	□
Diabetes	□	□
Kidney Diseases	□	□
AIDS or HIV Infection	□	□
Thyroid Problem	□	□

Do you have any of the following?	Yes	No
Heart Disease	□	□
Cardiac Pacemaker	□	□
Heart Murmur	□	□
Angina	□	□
Frequently Tired	□	□
Emphysema	□	□
Cancer	□	□
Arthritis	□	□
Joint Replacement/Implant	□	□
Hepatitis/Jaundis	□	□
Sexually Transmitted Disease	□	□
Anemia	□	□
Stomach Troubles/Ulcers	□	□

Do you have any of the following?	Yes	No
Chest Pains	□	□
Easily Winded	□	□
Stroke	□	□
Hay Fever/Allergies	□	□
Tuberculosis	□	□
Radiation Therapy	□	□
Glaucoma	□	□
Recent Weight Loss	□	□
Liver Disease	□	□
Heart Trouble	□	□
Respiratory Problems	□	□
Mitral Valve Prolapse	□	□
Other_____	□	□

DENTAL HISTORY

Name and location of previous dentist:_____ Date of last exam:_____

	Yes	No
1. Do your gums bleed while brushing/flossing?	□	□
2. Are your teeth sensitive to hot or cold?	□	□
3. Are your teeth sensitive to sweet or sour food?	□	□
4. Do you feel pain in any of your teeth?	□	□
5. Do you have any sores or lumps in or near your mouth?	□	□
6. Have you had any head, neck or jaw injuries?	□	□
7. Have you experienced any of the following problems in your jaw?		
Clicking	□	□
Pain (joint, ear, side of face)	□	□
Difficulty in opening/closing	□	□
Difficulty in chewing	□	□

	Yes	No
8. Do you have frequent headaches?	□	□
9. Do you clench or grind your teeth?	□	□
10. Do you bite your lips or cheeks frequently?	□	□
11. Have you had difficult extractions in the past?	□	□
12. Have you had prolonged bleeding following extractions?	□	□
13. Have you had orthodontic treatment?	□	□
14. Do you wear dentures or partials? If yes, date of placement_____	□	□
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	□	□
16. Do you like your smile?	□	□

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.

SIGNATURE:_____ ***DATE:***_____

FINANCIAL POLICY

At our practice, we make every effort to provide you with the finest care and the most convenient financial options. To do this, we will work hand-in-hand with you to maximize insurance reimbursement for covered procedures as well as suggest other payment option plans.

Our office treats patients' time and commitment to dental treatment seriously. The doctor reserves his time for each patient scheduled which allows the office to run smooth and quick. For this, we accept payment for services before or at the time services are rendered. This allows for patients to look forward to their visit here and know that they will be seen in a timely manner since their schedule was reserved. We accept Cash, Checks and all major Credit Cards as a form of payment. We also offer Interest-Free Financing, such as CareCredit to ensure that our outstanding services are available to everyone.

DENTAL INSURANCES

We gladly accept most PPO dental insurance plans as well as locals. Co-payments, if any, are due at the time of treatment. All insurance paperwork and filing of claims is done by our billing department.

If you have any questions about your insurance coverage, please call us at 973-239-3555. We DO offer free second opinion consults, free implant and Invisalign consultations and much more. We are here to help you.

CARECREDIT

CareCredit offers a comprehensive range of payment plans designed to help you fit dentistry into your budget. CareCredit is a revolving line of credit that can be used by the whole family for ongoing treatment without having to reapply.

With CareCredit you can:

- start treatment immediately
- enjoy low monthly payments
- finance up to 100% of your treatment plan
- have a choice of several payment plans
- pay no annual fee
- pay no upfront cost

_____ _____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)